Evidence for change of age & birth date of deceased is shown on.

FILM No. 100 FEB 26 1946

971 11967

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:
County: Baltimore
City or town: Sunnybrook
(If outside city or town limits, writes RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Jarrettsville Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Sunnybrook
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Jarrettsville Pike
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Ann Anderson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Hans Jakob Andersen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 4-1864 1874

8. AGE: Years	Months	Days	If less than one day
81 71	8	25	— hrs. — min.

9. Birthplace: County Wexford Ireland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: John Codd
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary A. Moran
15. Birthplace: Ireland

16. Informant: Miss Mary Anderson
Address: Sunnybrook, Balto. Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Maria Cemetery
Location: Towson, Md.

18. Funeral director: John Burns' Sons
Address: Towson, Md.

19. Dec. 28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1945 at 2.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1940, to Dec 26, 1945
and that I last saw h[illegible] alive on Dec. 22, 1945

Immediate cause of death	DURATION
Heart disease, chronic myocarditis, renal vascular involvement	2 yrs
Due to: Senile changes	Unknown
Due to: Arteriosclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rollin E. Hudson M.D.
M. D. or other
Address: Towson 4 Md Date signed 12/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 4 1946
BUREAU T.S.

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

11908

FILM No. I 00 JAN 8 1946

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Baltimore
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Reisterstown R.F.D. Painters Lane
Street No. (If rural, gives LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME William M. Armacost

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Margaret E. Armacost
6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) Nov. 22 1876

8. AGE: Years	Months	Days	If less than one day
69	0	20	hrs. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Mail Carrier (Retired)
11. Industry or business U.S. Government
FATHER 12. Name Thomas Armacost
13. Birthplace Carroll Co. Maryland
MOTHER 14. Maiden name Miss Hoffmaster
15. Birthplace
16. Informant Mr. J. Armacost
Address Woodlawn Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/15/45 (month) (day) (year)
Cemetery or crematory Meadow Branch
Location Carroll Co. Maryland
18. Funeral director Frank H. Newell
Address Pikesville, Maryland
19. 12-15 1945 (Date rec'd by registrar) Harry B. Ellis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1945 at 10:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1- 45 to 12-12-45
and that I last saw him alive on 12-12-45

Immediate cause of death	DURATION
myocarditis	
Due to Chronic Nephritis	
Due to Arteriosclerosis	
Due to Prostatitis & retention	
Other conditions Uremia	
Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE James L. Sadtler M. D. or other
Address Reisterstown, Md. Date signed 12-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DEC 18 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

11999

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Harrisonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Gamber
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Finksburg
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MARY E. ARNSBERGER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John F. Arnsberger deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1856

8. AGE: Years	Months	Days	If less than one day
89	5	22	hrs. min.

9. Birthplace: Penna
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Moses Stambaugh
13. Birthplace: Penna

MOTHER
14. Maiden name: ?? Miller
15. Birthplace: Penna

16. Informant: Mr. Clarence R. Black
Address: Marriottsvile

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-45 (month) (day) (year)
Cemetery or crematory: Ebenezer
Location: Winfield, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 12/26/1945 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26 1945 at 10 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 20, 1945 to Dec 26, 1945 and that I last saw h[illegible] alive on Dec 26 1945

Immediate cause of death	DURATION
Carcinoma Peritoneum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other
Address: Randallstown Date signed 12/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 15 1946
BUREAU

STATE OF MARYLAND—CERTIFICATE OF DEATH

11910

1. PLACE OF DEATH

County Baltimore (95-e) Registration Dist. No. 34

Village or City Mt. White House No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Emma J. Ashe

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac M. Ashe

6. DATE OF BIRTH (month, day, and year) May 23 - 1867

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland.

FATHER

13. NAME Elisha Coy

14. BIRTHPLACE (city or town) (State or country) Maryland.

MOTHER

15. MAIDEN NAME Catherine Bosson

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Mrs. Edw. Peregoy (Address) Parkton Md.

18. BURIAL, CREMATION, OR REMOVAL Place Mt. Carmel Date Jan 2, 1946

19. UNDERTAKER Edward L. Sipton (Address) Hampstead Md.

20. FILED Dec. 31, 1945 Cyril E. Franklin M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 30, 1945 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1945, to Dec 28, 1945

I last saw h-er alive on Dec 28, 1945; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute dilatation of heart	sudden
Angina pectoris, Cardiac asthma, Cardiac arrythmia	10 yrs

Other Contributory Causes of Importance:

Violent coughing and inability to get breath, Asterio-sclerosis	?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Cyril E. Franklin M. D.

(Address) Upperco Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

11911

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 34

1. PLACE OF DEATH:
County: Baltimore
City or town: Upperco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Trenton Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Upperco
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Trenton Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Martin Elicum Ayers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie Fishpaw
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Sept 1-1874

8. AGE: Years: 71 Months: 3 Days: 9 If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business: General

FATHER
12. Name: James ayers
13. Birthplace: Virginia

MOTHER
14. Maiden name: Janie sheets
15. Birthplace: Virginia

16. Informant: Mrs Martin ayers
Address: Upperco - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-12-45 (month) (day) (year)
Cemetery or crematory: Trenton
Location: Bald. Co.
18. Funeral director: Edw C Tipton
Address: Hampstead, Md

19. 12-11- 1945 (Date rec'd by registrar) C.E. Frantz M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-10 1945 at 9 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12-10- 1945, to 12-10- 1945 and that I last saw him ~~alive~~ on not seen alive 1945

Immediate cause of death	DURATION
Angina Pectoris	1 mo.
Due to	
Due to	
Other conditions	

(Incinde pregnancy witiin 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) None (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dr. D. D. Eagles Medical Examiner
M. D. or other
Address: Reisterstown, Md. Date signed: 12-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 13 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

CERTIFICATE OF DEATH

11912

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 yrs

Hospital, Institution, or street address where death occurred: Masonic Home, Cockeysville Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ridge Rd. Woodlawn Md

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Victor G. Backman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Elizabeth Hummel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 29 - 1861

8. AGE: Years	Months	Days	If less than one day
84	5	16	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Sampler

11. Industry or business

FATHER — 12. Name: John M. Backman

13. Birthplace: Germany

MOTHER — 14. Maiden name: Mary Seipp

15. Birthplace: Germany

18. Informant: Laura M. Schroeder

Address: Masonic Home, Cockeysville Md

17. Interment (Burial, cremation, or removal. Which?) Date thereof 12 - 18 - 45 (month) (day) (year)

Cemetery or crematory: Lorraine

Location: Balto. Md.

18. Funeral director: Geo L. Beyer Jr.

Address: 16 12 Hollins St.

19. 12/17/45 (Date rec'd by registrar) 19 45 L. M. Schroeder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 19 45 at 5:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 43 to Dec 15 19 45 and that I last saw him alive on Dec 15 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: Hypertensive Cardio Vascular disease	5 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. Bd. Sherman M. D. or other

Address: 2424 Eutaw Place Date signed 12/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 20 1945
BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ 11913

Reg. Dist. No. 6-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore,
City or town Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Dec. 24, 1945
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since Dec 24, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 28 W Joppa Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Martha Bagley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband Eugene Bagley
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 11, 1877

8. AGE: Years 68 | Months 7 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER 12. Name Thomas O. Ackey
13. Birthplace Baltimore County, Maryland

MOTHER 14. Maiden name Elizabeth Shamburger
15. Birthplace Baltimore County, Maryland

16. Informant Personal History- Hospital Records and Husband + Daughter
Address Eudowood Sanatorium Towson 4, Md.

17. Burial (Burial, cremation, or Removal. Which?) Date thereof Dec 31/1945 (month) (day) (year)
Cemetery or crematory Mayfield Chapel Cemetery
Location Timonium Balto. Co., Md.

16. Funeral director John Burns' Sons
Address Towson Md.

18. Dec 28, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1945, at 1:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 24 1945, to December 28 1945
and that I last saw h.e. alive on December 28 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	about 2½ mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE William A Bridges M. D. or other
Address Towson 4 Maryland Date signed 12-28-45

RECEIVED
JAN 7 1946
BUREAU V.S.

Evidence for addition of place of death & for change of date of death is shown on FILM No. 100 JAN 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

11914

Reg. Diat. No. 42

1. PLACE OF DEATH: 5234 Arbutus Ave

County.....

City or town Baltimore Co. -- Arbutus - Halethorpe P.O.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME Hattie D. Baird

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1860

8. AGE: Years	Months	Days	If less than one day
85	0	15	.....hrs. .....min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Bookbinding.

FATHER 12. Name James Baird

13. Birthplace Scotland

MOTHER 14. Maiden name Emma Kramer

15. Birthplace Wash. D.C.

16. Informant Susan J. Duffy

Address 5234 Arbutus Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 26, 1945 (month) (day) (year)

Cemetery or crematory Glen Wood

Location Wash. D.C.

18. Funeral director W. W. Chambers Co

Address Washington D.C.

19. Dec 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22, 1945, at .....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1942 to Dec 22 1945

and that I last saw her alive on Dec 21 1945

Immediate cause of death	DURATION
a Hemorrhage Peptic Ulcer	2 days
Due to Carcinoma Colon	unknown
Due to	
Other conditions Senard Arteriosclerosis	
c Hypertension (Include pregnancy within 3 months of death)	5 Years

Major findings of operation.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Elliot W. Johnson MD M. D. or other

Address 3452 Medical Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 28 1945
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

11915

Reg. Diat. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: 109 Oella Ave, Oella, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 Yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Oella
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 Oella Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: George Washington Barnes

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Fannie L. Barnes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 20, 1859

8. AGE: Years	Months	Days	If less than one day
86	8	26	..... hrs. ..... min.

9. Birthplace: Carroll Co, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Textile Worker
FATHER 12. Name: Joshua Barnes
13. Birthplace: Carroll Co., Md.
MOTHER 14. Maiden name: Clarissa Daniels
15. Birthplace: MARYLAND
16. Informant: Lawrence Leroy Barnes
Address: 109 Oella Ave., Oella, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18 1945 (month) (day) (year)
Cemetery or crematory: Wards Chapel
Location: Liberty Road
18. Funeral director: Easton Sons
Address: Ellicott City, Md.
19. 12-18 1945 (Date rec'd by registrar)
Harry D. Fuller Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1945, at 1:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/22 1945, to 12/15 1945
and that I last saw h.. l.. alive on 12/15 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 hr.
Due to: Arteriosclerotic Cardio-vascular disease	5 yr.
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George E. Burgoyne M.D. M. D. or other
Address: Ellicott City, Md. Date signed: 12/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 20 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (88-a)

CERTIFICATE OF DEATH

11916 38

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Stoneligh (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 600 Hatherleigh Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Stoneligh (If outside city or town limits, write RURAL and give nearest town)

Street No.: 600 Hatherleigh Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Allen W. Beam Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella Madinger Beam

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 10, 1893

8. AGE:

Years	Months	Days	If less than one day
52	10	9	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Secy. & Treas.

11. Industry or business: Liberty Finance Co

FATHER — 12. Name: Allen W. Beam Sr.

FATHER — 13. Birthplace: Manchester Md.

MOTHER — 14. Maiden name: Mary Godfrey

MOTHER — 15. Birthplace: Manchester Md.

16. Informant: Mrs. Ella M. Beam

Address: 600 Hatherleigh Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/22/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemt.

Location: Pikesville Md.

18. Funeral director: Wm. J. Tickner & Sons

Address: North & Pa. Aves.

19. Dec 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to Dec 19th 1945 and that I last saw h... alive on Dec 19th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: E. B. Butler M. D. or other

Address: 7201 York Rd Date signed: 12-21-45

Balto 12 - Md

RECEIVED
DEC 29 1945
BUREAU V. F.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11917

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 2 mos., 27 days
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 2 yrs., 2 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5407 Morello Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles Clayton Benson

3.(b) Social Security Number: 219-05-4244

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Audrey L. Benson
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): October 15, 1913

8. AGE: Years	Months	Days	If less than one day
32	2	9	..... hrs. ..... min.

9. Birthplace: Brandonville, West Virginia (Town, county, and state)
10. Usual occupation: Pay-master
11. Industry or business:

FATHER
12. Name: Charles A. Benson
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Flizabeth Pope
15. Birthplace: Pennsylvania

16. Informant: Charles C. Benson
Address: 5407 Morello Rd., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27, 1945 (month) (day) (year)
Cemetery or crematory: Parkwood Cemetery
Location: 3310 Taylor Ave., Balto., Md.

18. Funeral director: Eugene A. Ruck
Address: 5309 Harford Rd., Balto., Md.

19. Dec. 24, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24, 1945, at 8:30P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27, 1943, to Dec. 24, 1945 and that I last saw him alive on December 24, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart A Shaffer M.D. (M.D. or other)
Address: Mount Wilson, Md. Date signed: 12/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
DEC 27 1945
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11918 Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Mc Donogh, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3mo.; 9 da.
Hospital, institution, or street address where death occurred: McDonogh School
How long in hospital or institution? ***

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: McDonogh (If outside city or town limits, write RURAL and give nearest town)
Street No.: McDonogh School (If rural, give LOCATION)
2.(a) If veteran, name war: ***

3.(a) FULL NAME: DORIS CLEGGETTE BENTZ (Infant)

3.(b) Social Security Number: ***

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

B.(b) Name of husband or wife: ***
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): September 2, 1945

8. AGE:	Years	Months	Days	If less than one day
	0	3	9	... hrs. ... min.

9. Birthplace: McDonogh, Balto. Co., Md. (Town, county, and state)
10. Usual occupation: ***
11. Industry or business: ***

FATHER
12. Name: John C. Bentz
13. Birthplace: Bluefield, W. Va.

MOTHER
14. Maiden name: Nadine D. Quintal
15. Birthplace: San Antonio, Texas

16. Informant: John C. Bentz
Address: McDonogh School, McDonogh, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1945 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville, Balto. Co., Md.
18. Funeral director: Walter Brooks Bradley
Address: 1922 W. North Ave
19. 12/12/45 (Date rec'd by registrar) D. W. Hedrick, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 December 1945, at 9:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1945, to Dec 11 1945, and that I last saw h... alive on Dec 11 1945

Immediate cause of death	DURATION
Influenza	about 10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Karl W. Ebeling, M.D. or other
Address: 3311 St Paul St Date signed: 12-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

11919

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Owings Mills Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 8/28/45

Hospital, Institution, or street address where death occurred:
Rosewood St. Tr. School

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marg. H. Berger.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1/26/09

8. AGE: Years	Months	Days	If less than one day
36	11	10	..... hrs. ..... min.

9. Birthplace: Austria
(Town, county, and state)

10. Usual occupation: Stenographer or secretary

11. Industry or business: Hospital Attendant

FATHER
12. Name: George Berger
13. Birthplace: Sharndorf, Austria

MOTHER
14. Maiden name: Mary Emich
15. Birthplace: Austria

16. Informant: Rosewood staff
Address: Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9 1945 (month) (day) (year)

Cemetery or crematory: MT. Hope. Worth Township

Location: Cook Co. Ill.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown Md.

19. Dec 6 1945 (Date rec'd by registrar) Harry B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 5 1945, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1945, to Dec 5 1945 and that I last saw her alive on 1945

Immediate cause of death	DURATION
Hanging.	1 hr.
Due to: Dementia Precox	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 12-5-'45

Where did injury occur? Owings Mills, Balto. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Bed room

Means of injury: Hanging. Injured at work? No.

23. SIGNATURE: D. D. Caples, M.D. M.E.
M. D. or other

Address: Reisterstown, Md. Date signed 12-5-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

REC
DEC 11 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11920

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Mrs. Coale's Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Shady Nook Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Leonora Land Biggs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Francis F. Biggs

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 8, 1860

8. AGE: Years	Months	Days	If less than one day
85	11	11	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: Robert Hact Land

13. Birthplace: Va.

MOTHER

14. Maiden name: Antoinette Walker

15. Birthplace: Va.

16. Informant: Mrs. Antoinette Biggs Davis

Address: 304 Somerset Road, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Md.

18. Funeral director: John O. Mitchell & Sons, Inc.

Address: 1906 Eutaw Place, Balto. - 17 - Md.

19. 12/31 1945 (Date rec'd by registrar) Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1945, at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938 to Dec 29 1945 and that I last saw h.. alive on Dec 28 1945

Immediate Cause of death

Bronchopneumonia (Terminal)

My arteriosclerosis

Due to: Arteriosclerosis

Due to: Hypertension

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm Lamber Ford M. D. or other

Address: 20 E. Preston St., Balto. Date signed

RECEIVED
JAN 2 1946
BUREAU F R

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (46)

Registered No. 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore ~~City~~ Co. Maryland
(b) Street address 417 Moffle Lane - Turner Station
(c) Hospital or institution: Dundalk Balto. Co. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Turner Station Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Moffle Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Mae Blackston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1920

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Peter Fergus
13. Birthplace Va

MOTHER
14. Maiden Name Elmina?
15. Birthplace Va.

16 (a) Informant Peter Fergus
(b) Address Lawson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 31 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) 12/31/45 (Date rec'd by registrar) (b) Registrar

DEC 31 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26- 1945, at 9.30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-26- at 8.45- P. M.
(b) Where did injury occur? above residence
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - automatic pistol.

23. Signature Howard J. Munder M.D.
Medical Examiner.
Date signed 12-27-45-

Local Deputy

JAN 8 1946
BUREAU V B

11922

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-32)

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22
Hospital, institution, or street address where death occurred:
22 W. Penna. Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 22 W. Penna. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: NORA JONES BRUFF

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~: Thomas C. Bruff
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 22, 1853

8. AGE: Years	Months	Days	If less than one day
92	3	1	— hrs. — min.

9. Birthplace: Somerset Co., Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Benjamin I. Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jane Wayneuright
15. Birthplace: Maryland

16. Informant: Miss Dorothy Bruff
Address: 22 W. Penna. Ave., Towson, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Dec. 30, 1946 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Maryland
18. Funeral director: John Burns' Sons
Address: Towson, Md.
19. 12/30/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28, 1946 at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to Dec. 28 1946 and that I last saw h[er] alive on Dec. 26 1946

Immediate cause of death	DURATION
Myocardial Insufficiency	
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel J. Del Sha Jenkins M. D. or other
Address: Towson 4, Md. Date signed 12/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 10 1946
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11923

Reg. Dist. No. 194

1. PLACE OF DEATH:
County: Fairfax Co.
City or town: Centreville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Clarke
City or town: Berryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Kimble Hicks Byrne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) ~~Name of husband or~~ wife: Lillie Pierce Byrne
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 15 1862

8. AGE: Years	Months	Days	If less than one day
83	1	6	hrs. min.

9. Birthplace: Loudoun County Va.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Albert Lee Byrne
13. Birthplace: Loudoun Co. Va.
MOTHER 14. Maiden name: Evelina T. Hicks
15. Birthplace: Loudoun Co. Va.
16. Informant: Kimble B. Byrne Berryville Va
Address: 614 Plymouth Rd
17. ~~Burial~~ Interment Va. - Date thereof: 12-13-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Winchester Va.
Location
18. Funeral director: Charles F. Coles
Address: Berryville Va.
19. Dec. 21 1945 John B. Langhorne Clerk B.E.F. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 1945 at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 21 1945 and that I last saw him alive on Dec. 21 1945

	DURATION
Immediate cause of death: Lobar Pneumonia	3 days
Due to:	
Due to:	
Other conditions: Hypostatic Heart Decay	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jen C. Kuhlmann M.D.
M. D. or other
Address: Ellicott City Md Date signed: 12/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 28 1945
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11924

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
15 W. Chesapeake Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 15 W. Chesapeake Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: *********

3.(a) FULL NAME: MYRTLE MAY CARNELL

3.(b) Social Security Number: *******

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Herbert M. Carnell
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): December 26, 1903

8. AGE: Years	Months	Days	If less than one day
41	11	8	....hrs. ....min.

9. Birthplace: Franklin, W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: James Simpson
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Marie Hoover
15. Birthplace: W. Va.

16. Informant: Herbert M. Carnell
Address: 15 W. Chesa. Ave., Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 6 1945 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Maryland
18. Funeral director: John Burns Sons
Address: Towson, Maryland

19. Dec 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4, 1945, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-4 1945 to 12/4 1945 and that I last saw h.. alive on 12/4 1945

	DURATION
Immediate cause of death: Mitral Regurgitation	2 yrs
Due to:	
Due to: Myocardial Degeneration	5 days
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: David Miller MD
M. D. or other
Address: 1500 N Broadway Date signed: 12/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 29 1945
BUREAU V.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Edgemere
(b) Street address 1470 Oak Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Balto Md
(c) City or town Edgemere (If outside city or town limits, write RURAL and give town)
(d) Street No. 1470 Oak Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W Carter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Carter
13. Birthplace Md

MOTHER
14. Maiden Name Emma Carter
15. Birthplace Md

16 (a) Informant Annie Fahrer
(b) Address 505 W Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory John Wesley Cemetery
Location North Point Balto Co Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) 1/2 (Date rec'd by registrar) (b) 46 D.W. Medford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 25 to Dec 28-45 and that I last saw him alive on Dec 28-1945

Immediate cause of death: Lobar pneumonia — Duration: 4 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J.H. Thomas M. D.
Address Summit Sta. Date signed 1/2/46

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85a

[redacted] Registered No. 3 d 11926

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 611 Avondale Rd.

(c) ~~Hospital or institution:~~

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Towson Station
(If outside city or town limits, write RURAL and give town)

(d) Street No. 611 Avondale Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie M Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: C

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Matthew Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20th-1891

8. AGE: Years 54 | Months 5 | Days | If less than one day: 6 hr. 55 min.

9. Birthplace Montgomery Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown

13. Birthplace Unknown

MOTHER
14. Maiden Name Minnie Frazier

15. Birthplace Montgomery Md

16 (a) Informant Matthew H. Carter

(b) Address 611 Avondale Rd Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Halethorpe Md

18 (a) Funeral director George T. A. Gibson

(b) Address 1735 Druid Hill

19 (a) 12/27/45 (Date rec'd by registrar) (b) [redacted] Registrar

Harry W. Miller
Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1945; at 24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1945 to 12/14 1945, and that I last saw h[redacted] alive on 12/14 1945.

Immediate cause of death: Cerebral apoplexy & paralysis — Duration

Due to: Hypertension

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature B. M. R. Leetty M. D.

Address 2134 Druid Hill Date signed

DEC 22 1945

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

Evidence for addition of place of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11927

FILM No. I 00 JAN 11 1946

Reg. Dist. No. 45

1. PLACE OF DEATH:
County: Balto Co
City or town: Fork
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Susanna Chant

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 14 - 1876

8. AGE: Years 69 | Months 4 | Days 3 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: House work

11. Industry or business:

FATHER
12. Name: Louis C. Chant
13. Birthplace: England

MOTHER
14. Maiden name: Martha Robertson
15. Birthplace: Virginia

16. Informant: John H. Chant
Address: Hyde Md.

17. (Burial, cremation, or removal. Which?) Buried Date thereof Dec 19-45 (month) (day) (year)
Cemetery or crematory: Belmont Cem
Location: York Rd & Belmont Balto Md

18. Funeral director: Clarence E. Authur
Address: Fork Md.

19. Dec 18 19 45 (Date rec'd by registrar) C. E. Authur Deputy Seal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 19 45 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23 19 45, dec. 17 19 45, and that I last saw her alive on December 17 19 45

	DURATION
Immediate cause of death: Con. gestive Heart Failure	2 4 days
Due to: Arteriosclerotic Heart Disease	3 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D. M. D. or other
Address: Fork Md. Date signed 12/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 2 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

CERTIFICATE OF DEATH

11928 30

Reg. Diat. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: BALTO.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edmondson Ave. & Nunnery Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY JANE CHATTERTON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Willoughby Chatterton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 14, 1865

8. AGE: Years	Months	Days	If less than one day
80	8	9	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Janison

13. Birthplace: Balto., Md.

MOTHER — 14. Maiden name: Annie Body

15. Birthplace: Md.

16. Informant: Mrs. Frances Hosmer

Address: Gun Rd., Relay 27, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/45 (month) (day) (year)

Cemetery or crematory: Lorraine Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 12/26 19 45 (Date rec'd by registrar) A. W. Hebeck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23, 19 45, at 4:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 19 45, to December 23 19 45, and that I last saw h. alive on Dec 23 19 45.

	DURATION
Immediate cause of death: Myocardial insufficiency	
Due to: Arteriosclerotic type hypertrophy, with hypertrophy & congestive failure	2 yrs
Due to: Generalized arteriosclerosis with hypertension.	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury. Injured at work?

23. SIGNATURE: D. Michel M D (M. D. or other)

Address: 4901 Edmondson Ave. Date signed: Dec 24 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

11929

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs. 5 Mo. 8 days.
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: English Council Balto. 27, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2619 Tulip Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Helen Chornyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 11, 1917

8. AGE: Years	Months	Days	If less than one day
28	3	19	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Inmate, Rosewood State
11. Industry or business: Trainign School, Owings Mills

FATHER
12. Name: Paul Chornyer
13. Birthplace: Hungary

MOTHER
14. Maiden name: Mary Szkochek
15. Birthplace: Hungary

16. Informant: Institution records; Rosewood
Address: State Training School, Owings Mills, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 12/3/45 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem.
Location: Anne Arundel Co. Md
18. Funeral director: C. Vernon Lemmon
Address: 4611 Park Heights Ave.
19. 12/3 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1945 at 3:05 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1945 to Dec. 1 1945 and that I last saw her alive on Dec. 1 1945

Immediate cause of death	DURATION
Bronchopneumonia	6 days
Due to: Acute Bronchitis	16 days
Due to:	
Other conditions: Epilentic Quadriplegic Idiot	congenital.

(Include pregnancy within 3 months of death)

Major findings of operations: noen
Date of op.: none
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? NONE (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): None
Means of injury: None Injured at work?

23. SIGNATURE: George C. Medairy M. D.
M.D. or other
Address: George C. Medairy, M.D. Owings Mills, Md. Date signed: 12/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11930

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 23 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Warren Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Vernon Christy

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Hattie M. Christy
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 16, 1883

8. AGE: Years	Months	Days	If less than one day
62	2	3	..... hrs. ..... min.

9. Birthplace: Baltimore Co., Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Henry Christy
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Alice Greaser
15. Birthplace: Balto. Co., Md.

16. Informant: Harry Vernon Christy
Address: Warren Rd., Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 22, 1945 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Maryland

18. Funeral director: John Burns' Sons
Address: 612 York Rd., Towson, Md.

19. Dec. 19, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19, 1945 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26, 1945, to Dec. 19, 1945 and that I last saw h... im ...alive on December 19, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart A Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 12/19/45

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 26 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49)

CERTIFICATE OF DEATH

11931

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 233 Baltimore ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Margaret Christy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Christopher Christy
6.(c) If alive, give age: 79 years

7. Birth data of deceased (mo., day, yr.): June 29, 1869

8. AGE: Years	Months	Days	If less than one day
76	5	14	...hrs. ...min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

MOTHER FATHER
12. Name: Joseph Faustini
13. Birthplace: Italy
14. Maiden name: Angelina Cazlio
15. Birthplace: Italy

18. Informant: Mrs. Catherine Lord
Address: 233 Balto. Ave. Dundalk Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/17/45 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Dundalk Ave. Balto. Md
18. Funeral director: Frank H. Newell
Address: Pikesville, Md.
19. Dec 15 1945 (Date rec'd by registrar) Milton M. Smullen Local Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/13 1945 at 12 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to Dec. 1945 and that I last saw h... alive on Dec. 13 1945

Immediate cause of death: Carcinoma of Vulva — OURATION: 18 Mos
Due to: Ulcerated Pelvis Fabris
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Same
Date of op. June 45.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M B Davis M.D. M. D. or other
Address: Dundalk Md Date signed 12/15/45

RECEIVED
JAN 8 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-0

11932

CERTIFICATE OF DEATH

★ Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25
Hospital, institution, or street address where death occurred: 1904 Maxwell ave
How long in hospital or institution? 25 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1904 Maxwell ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME (Adelheid) Adelhaide Clausen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Wh	Widow

6.(b) Name of husband or wife: Geo Clausen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 23, 1854

8. AGE: Years: 91 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation:

11. Industry or business?

FATHER 12. Name: Unknown
FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Germany

16. Informant: Mrs Ziegler
Address: 1904 Maxwell Ave

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Dec 19 45 (month) (day) (year)
Cemetery or crematory: St Paul's Cem
Location:

18. Funeral director: L. Heemann & Son.
Address: 32 S. Broadway

19. 12/17/45 (Date rec'd by registrar) 19 J. McCormick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 19 45, at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	5 min
Due to: Pneumonia	June 45
Due to: Fractured left femur	July 45
Other conditions Due to: Accidental fall. Ward	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of July 4 45
Where did injury occur? Dundalk (City or town) Balto (County) Md (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: J. McCormick M.D. Deputy Medical Ex. M.D. or other
Address: Dundalk, Md. Date signed: 12/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr W. Cannel
88 Baldwin Ave

RECEIVED
JAN 8 1946
BUREAU V E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2nd)

CERTIFICATE OF DEATH

11933

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:
6924 Dogwood Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6924 Dogwood Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jane Elizabeth Clemons

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Thomas Clemons

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 12, 1869

8. AGE: Years	Months	Days	If less than one day
76	1	25	____ hrs. ____ min.

9. Birthplace: Parkersburg, W. Va.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Miss Mane
15. Birthplace: West Virginia

16. Informant: Mr. Hannibal Clemons
Address: 6924 Dogwood Road, Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 10, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Frankford, W. Va.

18. Funeral director: [illegible] Lamoreau

Address: 4510 Liberty Heights Ave.

19. 12/7/1945 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7 19 45, at 2.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7, 1945, to Dec 7, 1945 and that I last saw her alive on Dec 7, 1945

Immediate cause of death	DURATION
Chr. Valv. Heart Disease	3
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Harrisonville, Md. Date signed 12/7/45

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 15 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11934 P.

Reg. Dist. No. 4-4

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Vets.Adm. Hosp., Fort Howard, Md.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2902 Violet Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: MAX COHEN

3.(b) Social Security Number: 216-03-8601

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of ~~husband~~ or wife: Esther Cohen
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): October 25, 1895

8. AGE: Years	Months	Days	If less than one day
50	1	21	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Liquor Salesman
11. Industry or business:
FATHER 12. Name: Abraham Cohen
13. Birthplace: Russia
MOTHER 14. Maiden name: Sarah Solomon
15. Birthplace: Russia
16. Informant: Clinical Records, Vets.Adm.
Address: Fort Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 17, 1945 (month) (day) (year)
Cemetery or crematory: Hebrew Rosedale Cemetery
Location: Hamilton Ave
18. Funeral director: Sol Levinson & Bros
Address: 1124-1126 W North Ave
19. (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16th, 1945 19.... at 8:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 19 45, to Dec 16 19 45 and that I last saw h. im alive on December 16 19 45

Immediate cause of death	DURATION
Metestatic carcinoma (hypernephroma)	Undet.
left kidney - undet.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: A.M. BALTER, Lt.Col., M.C. CLIN. Dir
M. D. or other
Address: Vets.Adm.Ft.Howard, Md. Date signed 12-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

Reg. Diat. No. 11935 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Middle River Ave. Essex
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry R. Conklin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy E. Conklin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 28-1861

8. AGE: Years	Months	Days	If less than one day
84	9	1	..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: Street Cleaner
11. Industry or business

FATHER
12. Name: Conklin
13. Birthplace: Not Known

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: Dorothy E. Conklin
Address: Middle River Ave. Balto. Co. Essex

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2/46 (month) (day) (year)
Cemetery or crematory: Buffal* Baltimore Cem.
Location: North Ave. & Gay St.

18. Funeral director: John A. Miller
Address: 2334 Jefferson St.

19. Dec. 31 (Date rec'd by registrar) 19 45 John B. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 Dec 45 19 ..... at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 5 19 45, to Dec 26 19 45
and that I last saw h...s alive on 26 Dec 19 45

Immediate cause of death	DURATION
Cardiac failure	
Due to: Arteriosclerotic heart disease	2 mos.
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas B. Quigley M.D.
M. D. or other
Address: 815 Eastern Ave Balto 24 Md. Date signed: 12/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11936 P

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8yr 4mo 28da
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 8 yr 4mo 28da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rosewood St. Training School
(If rural, give LOCATION)
2.(a) If veteran, name war: -----

3.(a) FULL NAME: Nicholas Burns Cottle

3.(b) Social Security Number: -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 6/30/30

8. AGE: Years	Months	Days	If less than one day
15	5	12	____ hrs. ____ min.

9. Birthplace: Richland, N.C. (Town, county, and state)

10. Usual occupation: Inmate

11. Industry or business:

FATHER 12. Name: Earl Cottle
FATHER 13. Birthplace: Richland, N.C.

MOTHER 14. Maiden name: Sylvia Elza
MOTHER 15. Birthplace: Whitmer, W. Va.

16. Informant: Institutional records
Address: Rosewood St. Training School

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15. 45 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Annapolis R.D.

18. Funeral director: KUCHAUSKAS Funeral Home
Address: 637 Washington Blvd.

19. 12/14/45 (Date rec'd by registrar) A. W. Hedrick Registrar
DMA

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 19 45 at 5:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 19 45 to Dec. 12 19 45 and that I last saw him alive on December 12 19 45

Immediate cause of death	DURATION
Broncho-pneumonia	2 da
Due to: Acute bronchitis	5 da
Due to:	
Other conditions: Spastic quadriplegia (Include pregnancy within 3 months of death)	8yr 5mo plus

Major findings of operations: ____ Date of op.: ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: H G Butler M.D. M. D. or other
Address: Owings Mills, Md. Date signed: 12/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-b)

CERTIFICATE OF DEATH

11937 38

Reg. Dist. No.

1. PLACE OF DEATH:
County: BALTIMORE
City or town: TOWSON (WILTONDALE)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 YRS.
Hospital, Institution, or street address where death occurred: 506 YARMOUTH ROAD
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 506 Yarmouth Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SUSANNAH GERTRUDE COX

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	MARRIED

B.(b) Name of husband or wife: WM. NORRIS COX, SR.
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): APRIL 1, 1887

8. AGE: Years	Months	Days	If less than one day
58	8	28	____ hrs. ____ min.

9. Birthplace: ROANOKE, VIRGINIA
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business:

FATHER
12. Name: HENRY CLAY SMITH
13. Birthplace: KENT CO., Md.

MOTHER
14. Maiden name: MARTHA STEVENS
15. Birthplace: BAGDAD, PENNA.

16. Informant: WM. N. COX, SR.
Address: 506 YARMOUTH RD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: DEC. 31, 1945 (month) (day) (year)
Cemetery or crematory: GOVANS PRESBYTERIAN
Location: YORK Rd. BALTO., MD.

18. Funeral director: Walter Brooke Bradley
Address: 1922 W. NORTH AVE. (17)

19. 12/31 1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1945 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1945, to Dec. 29 1945
and that I last saw her alive on Dec. 28 1945

	DURATION
Immediate cause of death	
Carcinoma (Generalized) Primary in Uterus.	At least 1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. T. Cole M. D. or other
Address: 6014 York Road Date signed: 12-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 3 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

11938

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:
County: Baltimore,
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred:
Vets.Adm.Hosp. Fort Howard, Md.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2731 Parkwood Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: JAMES P. CRAGG (James Philip Cragg)

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: XXXX Lena M. Cragg
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): July 12, 1890

8. AGE: Years	Months	Days	If less than one day
55	5	4	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Expeditor
11. Industry or business: Glenn L. Martin Co.

FATHER
12. Name: XXXXXX John I. Cragg
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: XXXXXX Emma C. Weissner
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets Adm.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/19/45 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore, Md.

18. Funeral director: Wm. J. Tickner & Sons, Inc.
Address: North & Pa. Aves. Baltimore, Md.

19. 12/17 1945 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16, 1945, at 5:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5 1945, to December 16 1945 and that I last saw him alive on December 16 1945

Immediate cause of death	DURATION
Pneumonia, lobular, bilaterial	3 days
Due to	
Due to	
Arterial hypertension	Unknown
Other conditions: Atelectasis, left lung	14 days
Alcoholism, chronic	Unknown

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: A.M. BALTER, Lt.Col., M.C. Clin.Dir. M. D. or other
Address: Vets.Adm.Ft.Howard, Md. Date signed 12-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11939

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 9 mos. 21 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hosp.

How long in hospital or institution? 2 yrs. 9 mos. 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 N. Pearl St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Annie Cromwell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John Cromwell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 15, 1869 (?)

8. AGE: Years	Months	Days	If less than one day
76 ~~86~~(?)	3	15 ~~16~~	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Unknown Mr Spence

13. Birthplace: Unknown

MOTHER 14. Maiden name: Annie Welch

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Spring Grove State Hospital.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2 - 46 (month) (day) (year)

Cemetery or crematory: Loudon Pk. Cem

Location: Baltimore Md

18. Funeral director: E. W. Lamoreaux

Address: 1003 W. Baltimore St

19. 1/2/31 1945 (Date rec'd by registrar) Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1945, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1943, to Dec. 30 1945 and that I last saw h.e.r. alive on Dec. 30 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Indef.
Due to: Generalized Arterio-sclerosis	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Andrew Irwin, M.D. M. D. or other

Address: Spring Grove State Hosp. Date signed: 12-31-45

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 2 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

11940 41
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 19 Liberty Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Milton E. Crummey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary A Crummey
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Aug 21 1888

8. AGE: Years	Months	Days	If less than one day
57	4	3	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Melter
11. Industry or business: Sparrows Point
FATHER 12. Name: Edw Crummey
13. Birthplace: Pa
MOTHER 14. Maiden name: Catharine Jayes
15. Birthplace: Pa
16. Informant: Mrs Mary Crummey
Address: 19 Liberty Parkway
17. Burial (Burial, cremation, or removal. Which?) Data thereof Dec 26-45 (month) (day) (year)
Cemetery or crematory: Morland
Location: Balto Co Md
18. Funeral director: Uelmen Funeral Home
Address: 2008 Orleans St
19. 12/26/45 (Date rec'd by registrar) J M Carmine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23. 1945, at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to Dec. 1945
and that I last saw him alive on Dec. 22 1945

Immediate cause of death	DURATION
Hypertension C-V-R Disease	5 yrs
Due to: Cerebral Accident	1 yr
Due to:	
Due to:	2 days
Other conditions: Pulmonary Broncho Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. C. Davis M.D. M.D. or other
Address: Dundalk, Md Date signed: 12/26/45

RECEIVED
JAN 8 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11941

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 89 days

Hospital, institution, or street address where death occurred:

Vets.Adm.Hosp. Fort Howard, Maryland

How long in hospital or institution? 89 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 536 N. Carey St. Balto. Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2 ✓

3.(a) FULL NAME: ROBERT SAMUEL DAILEY

3.(b) Social Security Number: 105-14-155

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Anna Dailey

6.(c) If alive, give age: 47 yrs years

7. Birth date of deceased (mo., day, yr.): February 25, 1897

8. AGE:	Years	Months	Days	If less than one day
	48	9	25	...hrs. ...min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: South Carolina

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27 45 (month) (day) (year)

Cemetery or crematory: Balto. National

Location: Baltimore, Md.

18. Funeral director: Charles R Law

Address: 802 Madison ave.

19. 12/26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 19 45 at 8:16P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 22 19 45 to December 20 19 45

and that I last saw him alive on December 20, 19 45

Immediate cause of death	DURATION
Tuberculosis, chr., pulmonary, far advanced, active	12mos. plus
Due to	
Due to	
Other conditions: Hernia, inguinal, bilateral, incomplete	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work? No

23. SIGNATURE: H.Y.RICHARDS, MAJOR, M.C.ACT.CLIN.DIR. M. D. or other

Veterans Administration

Address: Fort Howard, Md. Date signed: 12-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9sd

CERTIFICATE OF DEATH

11942 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 6 mths, 16 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hosp.

How long in hospital or institution? 3 yrs, 6 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2110 N. Charles Street.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ~~Minnie~~ Mary K. DAWSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widowed.

6.(b) Name of husband or wife William F. DAWSON.

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 27, 1862

8. AGE: Years	Months	Days	If less than one day
83	8	28	hrs. min.

9. Birthplace ~~Delaware~~ Virginia
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John Kine

13. Birthplace Fredericksburg Va

MOTHER 14. Maiden name Mary Robinson

15. Birthplace Fredericksburg, Va.

16. Informant Capt. Frank H. Dawson

Address Fort Dill Field Tampa Florida

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28 1945 (month) (day) (year)

Cemetery or crematory London Park Cem.

Location Baltimore Md.

18. Funeral director Francis C. Byfer

Address 1000 N. North Ave

19. 12/27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13th 1945, to Dec. 25 1945 and that I last saw her alive on Dec 25 1945

Immediate cause of death	DURATION
Terminal Bronchio-Pneumonia	24 hrs
Due to Cardiovascular failure	2 mths
Due to Chronic myocarditis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Doctor Frank M.D. M. D. or other

Address Spring Grove Catonsville Date signed Dec 25 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 11943 47

1. PLACE OF DEATH:

County: Balto.

City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
2100 Smith Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2100 Smith Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE HENRY DEERING

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma (Ruhl) Deering

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 28, 1882

8. AGE: Years	Months	Days	If less than one day
62	11	28	..... hrs. ..... min.

9. Birthplace: Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation: Road Supervisor

11. Industry or business: Balto. Co.

FATHER
12. Name: Henry Deering
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Romelia Ann Wade
15. Birthplace: Balto. Co., Md.

16. Informant: Mrs. Emma Deering
Address: 2100 Smith Ave. Lansdowne, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

19. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19 Dec 27 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26, 19 45, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 19 ..... to Dec 26 19 45 and that I last saw h... alive on Dec 20 19 45

Immediate cause of death	DURATION
Uremia	1 wk
Due to Hemiplegia	18 yrs
Due to Cerebro vascular renal disease	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 2470 Mark Ct. Date signed 12-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 29 1945
BUREAU V.S.

State of Maryland

~~BALTIMORE CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address 25 Edmondson Ridge Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED: 11944
(a) State Md. (b) County Bone Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 Edmondson Ridge Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Medairy Dell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife Florence Mary Hampson

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1868

8. AGE: Years 77 | Months 11 | Days 18 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Insurance salesman

11. Industry or business

FATHER
12. Name Thomas E. Dell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amelia Mills
15. Birthplace Maryland

16 (a) Informant Albert H. Dell
(b) Address 6114 Montrose Rd., Cheverly, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount & North Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 12-29-45 (Date rec'd by registrar) (b) Harry H. Muller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 19 45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945, to Dec 22 1945; and that I last saw h alive on Dec 22 1945.

Immediate cause of death: Cardiac Arrest — Duration: 3 days

Due to: Hypertension — Duration: 2 years

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Bowman M. D.

Address 1022 E Pratt St Date signed 12/24/45

VS 150

RECEIVED
JAN 2 1946
BUREAU V E

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11945 31

Reg. Diat. No.

1. PLACE OF DEATH:

County: Balto.

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6727½ Windsor Mill Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6727½ Windsor Mill Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JOHN G. DIETRICH

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Regina R. Dietrich

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1871

8. AGE: Years	Months	Days	If less than one day
74	10	4	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Stationary Engineer (retired)

11. Industry or business

FATHER — 12. Name: John Dietrich

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mrs. J. R. Dietrich

Address: 3010 Glendale Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/45 (month) (day) (year)

Cemetery or crematory: Western Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 12/27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24, 1945 at 5:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1940 to Dec 24 1945

and that I last saw him alive on Dec 24 1945

Immediate cause of death	DURATION
Cardiac Decompensation	2 min.
Due to: Arteriosclerosis.	Yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M Bauman Lloyd M. D. (M. D. or other)

Address: 2200 Garrison Blvd Date signed: 12-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (4)

Reg. Dist. No. 43

11946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Overlea
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 33 Greenwood Avenue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 1½ yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Greenwood Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? no years

3 (a) **FULL NAME** Frank Alvin Donat

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1880

8. AGE: Years	Months	Days	If less than one day
65	3	21	hr. min.

9. Birthplace Tamaqua, Pa.
(Town, county, and state)

10. Usual occupation electrician - retired

11. Industry or business

FATHER
12. Name Eli Donat
13. Birthplace Tamaqua, Pa.

MOTHER
14. Maiden Name Mary DeFrehn
15. Birthplace ?

16 (a) Informant Walter Bennett
(b) Address 33 Greenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Odd Fellows
Location Tamaqua, Pa.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore, Md.

19 (a) 12/30/45 (Date rec'd by registrar) (b) A. W. Hedrich, Registrar

MEDICAL CERTIFICATION

20. Date of death Dec 30 1945, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1945, to Dec 30 1945, and that I last saw him alive on Dec 30 1945.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arterio-Sclerotic	
Cardio Vascular disease	
Due to with hypotension	
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

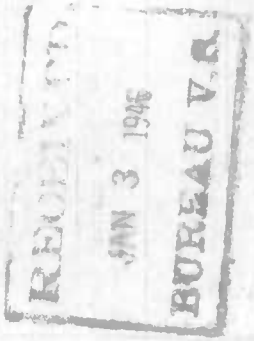
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Baumgardner, M. D. or other
Address Balto 6 Date signed 12-30-45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


JAN 3 1946
BUREAU V.

11947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 mos., 4 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 2 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1239 Stevens Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dorothy E. Dorsey

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Paul Dorsey
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): August 12, 1919

8. AGE: Years	Months	Days	If less than one day
26	4	14	...hrs. ...min.

9. Birthplace: Brooklyn, New York (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: James Stewart
13. Birthplace: Scotland
MOTHER 14. Maiden name: Irene Rodgers
15. Birthplace: Brooklyn, New York
16. Informant: Dorothy Dorsey
Address: 1239 Stevens Ave., Arbutus, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 29, 1945 (month) (day) (year)
Cemetery or crematory: Western Cemetery
Location: Edmondson Ave., Baltimore, Md.
18. Funeral director: F. B. Wippert & Son
Address: Eutaw Place, Baltimore, Md.
19. Dec. 26, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26, 1945 at 10:13 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 22, 1944 to Dec. 26, 1945 and that I last saw her alive on December 26, 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	3 yrs., 4 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Gangrene of lung	1 week

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

RECEIVED
DEC 29 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

119484

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bird River Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward E. Drebing

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Luella Drebing

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 13th, ~~1845~~ 1879

8. AGE: Years	Months	Days	If less than one day
66	4	4	..... hrs. ..... min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)

10. Usual occupation Ship Joiner

11. Industry or business

FATHER 12. Name George M. Drebing

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Murray

15. Birthplace Maryland

16. Informant Mr. Elander Drebing

Address 3426 Dudley Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/21/45 (month) (day) (year)

Cemetery or crematory Orems Methodist

Location Stemmers Run, Maryland

18. Funeral director Loveable Funeral Home

Address 7401 Belair Road

19. 12/26 19 45 Dawson L. Farber (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17th, 19 45 at 11.30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 14 19 45 to Dec. 17 19 45

and that I last saw h. alive on Dec. 14 19 45

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter A Anderson M. D. or other

Address 3001 Shannon Drive Date signed 12/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A45

RECEIVED
DEC 27 1945
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11949 P

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: BALTIMORE
City or town: DUNDALK.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 MONTHS
Hospital, institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: BALTIMORE
City or town: DUNDALK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2984 SOLLERS POINT ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: EDITH M DUNTON

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: AUBREY A. DUNTON
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): FEB. 24, 1894

8. AGE: Years	Months	Days	If less than one day
51	9	12	...hrs. ...min.

9. Birthplace: IRVINGTON VIRGINIA (Town, county, and state)
10. Usual occupation: HOUSE WIFE
11. Industry or business: —

FATHER
12. Name: GARRETT P. MESSICK
13. Birthplace: SOMERSET Co. Md.

MOTHER
14. Maiden name: ELLA PANSOST
15. Birthplace: ? Md.

16. Informant: GARRETT A. DUNTON
Address: 2986 SOLLERS PT. Rd.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: DEC 10 1945 (month) (day) (year)
Cemetery or crematory: LORRAINE PARK
Location: WOODLAWN Md.

18. Funeral director: WILLIAM J. TICKNER & SONS
Address: NORTH & PENN. AVES.

19. 12/10 1945 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC. 6 1945, at 10.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC 6 1945 to DEC 6 1945 and that I last saw h.. alive on DEC 6 1945

	DURATION
Immediate cause of death: CEREBRAL HEMORRHAGE, CARDIAC FAILURE	5 hrs.
Due to: HYPERTENSIVE C.V. DISEASE	2 YRS.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Stephen C. Mackenzie, M. D. or other
Address: 6714 Holabird Ave. Date signed: 12/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd V.S.
12/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11950

★ Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Idlewylde (Balto. 12)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
6300 Banbury Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Idlewylde (Balto. 12)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6300 Banbury Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MARY C. DURHAM

3.(b) Social Security Number
****

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Franklin P. Durham

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): March 28, 18 68

8. AGE: Years	Months	Days	If less than one day
77	8	3	hrs. min.

9. Birthplace: Harford Co., Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: William Kean
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lorenda Devoe
15. Birthplace: Maryland

16. Informant: Mrs. William P. Smith

Address: 6300 Banbury Rd, Balto.12,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3,1945 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Parkville, Maryland

18. Funeral director: John Burns' Sons

Address: Towson, Maryland

19. Dec. 3 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1, 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 21 19 45, to Dec 1 19 45, and that I last saw h alive on Nov 29 19 45.

Immediate cause of death	DURATION
Coronary Thrombosis	3 days
Due to	
Due to	
Other conditions: Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. N. Pearce M. D. or other

Address: 2105 Charles Date signed: Dec 2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 29 1945
BUREAU OF

11951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47a

CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH:
County: Balto.
City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Glyndon
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Alexius A. Dyer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Mary Dyer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1875

8. AGE: Years	Months	Days	If less than one day
70	3	15	hrs. min.

9. Birthplace: Balto. Co.
(Town, county, and state)
10. Usual occupation: Quarrier
11. Industry or business

FATHER
12. Name: Patrick Dyer
13. Birthplace: Ireland

MOTHER
14. Maiden name: Maria Egan
15. Birthplace: Ireland

16. Informant: Frank Dyer
Address: Glyndon, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26, 1945 (month) (day) (year)
Cemetery or crematory: New Catherdal
Location: Baltimore City
18. Funeral director: J.F. Eline & Sons
Address: Reisterstown, Md.

19. 12-26 1945 (Date rec'd by registrar) Mary A. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1945 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1945, to Dec 25 1945 and that I last saw h[illegible] alive on 12-23 1945

Immediate cause of death	DURATION
Ca. of Larynx	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. D. Eaples, M.D. Medical Examiner
M. D. or other
Address: Reisterstown Md Date signed: 12-26-'45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 28 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-0)

CERTIFICATE OF DEATH

11952

Reg. Diat. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Govans

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Armacost Nursing Home 812 Register Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Kingsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Belair Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Laura V. Edmeades

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William T. Edmeades

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1st 1865

8. AGE: Years	Months	Days	If less than one day
80	5	4	....hrs. ....min.

9. Birthplace Balto. Co. Maryland (Town, county, and state)

10. Usual occupation At Home

11. Industry or business ? Taylor

FATHER 12. Name ? Taylor

FATHER 13. Birthplace Pennsylvania

MOTHER 14. Maiden name Mary J. Groscup

MOTHER 15. Birthplace Pennsylvania

16. Informant Mr. Harry Edmeades

Address Kingsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 7 1945 (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore, Maryland

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Road

19. 12/6 1945 (Date rec'd by registrar) A. W. Baron Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5th 1945, at 3.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945 to Dec 5 1945 and that I last saw h... alive on 12/5/45 1945

Immediate cause of death	DURATION
Cardio-Vascular Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sylvia W. Fuller M. D. or other

Address 2723 Hartsdale Rd Date signed 12/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11953

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 days

Hospital, institution, or street address where death occurred: Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 46 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 909 Park Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: HERMAN ELLIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	married

6.(b) Name of husband or wife: Mary Ellis

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): August 15, 1898

8. AGE: Years	Months	Days	If less than one day
47	4	7	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: James Ellis

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetary

Location: Baltimore, Maryland

18. Funeral director: Mrs. Samuel T. Hemsley

Address: 578 W. Biddle St. Balto., Md.

19. 12/26/45 (Date rec'd by registrar) 19.... A W Kedrick per DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22, 1945, at 5:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 1945, to December 22 1945

and that I last saw h... im ...alive on December 22 1945

Immediate cause of death	DURATION
Lobar Pneumonia, left lower lobe	approx. 3 days
Due to	
Due to	
Other conditions: Abscess, iliopsoas, right	approx. 6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: H. Y. RICHARDS, MAJOR, M.C. ACT. CLIN. DIR. Veterans Administration M. D. or other

Address: Fort Howard, Md. Date signed 12-22-45

11954

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Baltimore.
City or town: Rural near Whitehall
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Shane.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Wilbert Enfield.

3.(b) Social Security Number: 218-09-7967.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Serena Enfield.
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): February 10, 1884.

8. AGE: Years	Months	Days	If less than one day
61	10	17	hrs. min.

9. Birthplace: Bridgeton, Pa. (town, county, and state)
10. Usual occupation: Carpenter.
11. Industry or business: Carpentering.
FATHER 12. Name: William Enfield.
13. Birthplace: Penna.
MOTHER 14. Maiden name: Phoebe Jane Beckwith.
15. Birthplace: Penna.
16. Informant: Mrs. Serena M. Enfield.
Address: White Hall, Md. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 30 1945 (month) (day) (year)
Cemetery or crematory: West Liberty
Location: White Hall, Md. R.D.
16. Funeral director: Noah Hartsfield
Address: New Freedom, Pa.
19. Dec 28 1945 (Date rec'd by registrar) Chester L. Feddon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 1945 at 2:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Dec 27 1945 and that I last saw h. alive on Dec 27 1945

Immediate cause of death	DURATION
Carcinoma of the Stomach	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lewis D. Shaut M.D. M. D. or other
Address: Shrewsbury, Pa. Date signed: 12-29-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 7 1946
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11956

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yr. 7 mo. 24 da.

Hospital, institution, or street address where death occurred:
Rosewood State Training School

How long in hospital or institution? 7 yr. 7 mo. 24 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rosewood State Training School
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: Robert Ewing

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -----

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 9/12/32

8. AGE: Years	Months	Days	If less than one day
13	2	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Inmate

11. Industry or business:

FATHER
12. Name: Robert A. Ewing
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Marguerite Wineke
15. Birthplace: Baltimore, Md.

16. Informant: Institutional records

Address: Rosewood State Training School

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 6/45 (month) (day) (year)

Cemetery or crematory: St. Charles

Location: Pikesville

18. Funeral director: Frank H. Newell

Address: Pikesville, Maryland

19. 12-4-45 (Date rec'd by registrar) Dr E E Nichol mm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1945, at 3:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1938, to Dec. 3 1945 and that I last saw him alive on December 3 1945

Immediate cause of death	DURATION
Broncho-pneumonia	4 da.
Due to: Bronchitis	2 da.
and Due to: Serial Epilepsy	3 da.
Other conditions: Grand mal epilepsy	7yr 7mo+

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isabel H. McClinton M.D. (M. D. or other)

Address: Owings Mills, Md. Date signed: 12/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

11955

Reg. Diat. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Presbyterian Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: none
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bolton St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary E. Finnister

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 16, 1861

8. AGE: Years	Months	Days	If less than one day
84	2	9	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Benjamin Anton
13. Birthplace: Va.

MOTHER
14. Maiden name: Alice Hansen
15. Birthplace: Va.

16. Informant: Mrs. T. E. Elliott, Supt.
Address: Presbyterian Home, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/45 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Baltimore, Md.

18. Funeral director: John C. Mitchell & Sons, Inc.
Address: 1900 Eutaw Place, Balto. - 17 - Md.

19. Dec 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945, at 1/25 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 1944 to Dec 23 1945 and that I last saw her alive on Dec 23 1945

Immediate cause of death	DURATION
Carcinoma Rectum	1 1/2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. M. D. or other
Address: Allegheny Ave., Towson, Md. Date signed: 12/26/45

RECEIVED
FEB 3 1946
BUREAU V. H.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

CERTIFICATE OF DEATH

11957 38

Reg. Diat. No. .....

P

1. PLACE OF DEATH:

County ..... Baltimore

City or town ..... Stoneleigh

(If outside city or towu limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? ..... 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md. County ..... Baltimore

City or town ..... Stoneleigh

(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... Stoneleigh Manor

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Grace Brown Fischer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife ..... Philip L. C. Fischer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ..... Jan 4 1871

8. AGE:

Years	Months	Days	If less than one day
74	11	11	..... hrs. ..... min.

9. Birthplace ..... Balto Md

(Town, county, and state)

10. Usual occupation ..... Housewife

11. Industry or business .....

MOTHER / FATHER

12. Name ..... George Brown

13. Birthplace ..... Balto Md

MOTHER

14. Maiden name ..... Sarah Sharp

15. Birthplace ..... Boston Mass

16. Informant ..... Mrs. John M. Myers

Address ..... 327 Bretton Rd.

17. ..... Date thereof ..... Dec 18 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... Green Mount

Location ..... Balto Md

18. Funeral director ..... Henry W. Perkins & Son Co

Address ..... McCulloh & Richard Sts.

19. ..... 19..... .....

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... 12/15 ..... 1945 ..... at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/13 ..... 1945 ..... to ..... 12/15 ..... 1945.

and thet I last saw h... alive on ..... 12/15/45 ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	3-5 days
Due to Arteria Sclerosis	Unknown
Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE ..... W H Roady M. D. or other

Address ..... 1402 Park Ave Date signed 12/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(H) MARGIN RESERVED FOR BINDING

Dr. Moody
1403 Park Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

11958

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sister Mary Biliana Fouquet

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 15, 1871

8. AGE: Years	Months	Days	If less than one day
74	3	28	..... hrs. ..... min.

9. Birthplace: Rochester N.Y. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Philip Fouquet

13. Birthplace: Bavaria Germany

MOTHER — 14. Maiden name: Margaret Stahl

15. Birthplace: Swabia Germany

16. Informant: Sr. Mary Clara

Address: Notch Cliff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 17/45 (month) (day) (year)

Cemetery or crematory: Notch Cliff

Location: Glen

19. Funeral director: Geo M. Gontz Inc

Address: 511 N. Howard St

19. Dec 14-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13 19 45 at 4.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 13 19 45, to Dec. 13 19 45 and that I last saw her alive on Dec. 5, 19 45

Immediate cause of death	DURATION
Gastric Carcinoma	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address Date signed

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 415

RECEIVED
DEC 20 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

11959 43

Reg. Dist. No.

1. PLACE OF DEATH:

County 3207 Putty Hill Ave

City or town Parkville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

3207 Putty Hill Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Antonia Frederick

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Isaac Frederick

7. Birth date of deceased (mo., day, yr.) June 30 1866 B.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
79	6	1	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mrs Wm. F Class

Address 3207 Putty Hill Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 1946 (month) (day) (year)

Cemetery or crematory St Johns Lutheran

Location Baltimore County

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Road

19. Jan 2 1946 (Date rec'd by registrar) Wm A L Reynolds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1945 19..... at 3.00 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1940 to Dec. 31 1945 and that I last saw h.... alive on Dec. 30 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	36 hrs
Due to Hypertensive Cardio-Vascular Disease	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D.

M. D. or other

Address Fork Md. Date signed 12/31/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 3 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11960

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore - Zone 19 -
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 yrs.
Hospital, institution, or street address where death occurred: Box 295 R10 - North Point Rd
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Rt #1.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Joseph Fryer.

3.(b) Social Security Number: 213-07-1511

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married.
6.(b) Name of husband or wife: Viola M. Fryer.
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): May 21. 1876.
8. AGE: Years 69 Months 6. Days 22 If less than one day ... hrs. ... min.
9. Birthplace: Baltimore - City - Md.
(Town, county, and state)
10. Usual occupation: Machinist.
11. Industry or business: Steel plant.
FATHER 12. Name: Thomas J. Fryer.
13. Birthplace: Balto. Md.
MOTHER 14. Maiden name: Julia Stevens.
15. Birthplace: Philadelphia. Pa.
16. Informant: Viola M. Fryer
Address: Rt #1.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12 15 45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto Md.
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd
19. DEC 13 1945 Dawson L. Harbes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 12. 1945, at 4:45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1937, to Dec 12. 1945 and that I last saw him alive on Dec. 12. 1945.

	DURATION
Immediate cause of death: Heart Block.	10 days.
Due to: Myocardial degeneration	3 wks.
Due to: Broncho pneumonia. Dec. 4 to 9. 1945.	
Other conditions: Hypertensive	9 yrs.
Arteriosclerosis vascular disease.	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Louis N. Pollin. M.D. M. D. or other
Address: Sparrows Point - Md. Date signed: 12/12/45

RECEIVED
DEC 18 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11961

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 days
Hospital, Institution, or street address where death occurred:
Vets.Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 87 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3802 Fernhill Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I ✓

3. (a) FULL NAME: REARDON FUSSELBAUGH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Bertha F. Fusselbaugh
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): December 27, 1891

8. AGE: Years	Months	Days	If less than one day
53	11	27	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Estimator
11. Industry or business:
FATHER — 12. Name: Robert Fusselbaugh
13. Birthplace: Maryland
MOTHER — 14. Maiden name: Emma Presstman
15. Birthplace: Maryland
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville
18. Funeral director: John O. Mitchell & Sons
Address: 1600 Eutaw Place
19. 12/24/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 19 45, at 2:25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28 19 45 to December 24 19 45 and that I last saw him alive on December 24 19 45

Immediate cause of death	DURATION
Heart disease. Hyper-tension and coronary arteriosclero-sis, myocardial insufficiency	6 months
Due to:	
Due to:	
Other conditions: Broncho-pneumonia	Terminal
Interstitial nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A.M.BALTER, LT.COL., M.C. CLIN.DIR.
M. D. or other
Address: Fort Howard, Md. Date signed: 12-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

11962 32
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Pikesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Brightside ave.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Ida Louise Garrish

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Charles Garrish
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 22 - 1874

8. AGE: Years	Months	Days	If less than one day
71	5	29	hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William Menzel
13. Birthplace Germany

MOTHER
14. Maiden name Louise Stanzel
15. Birthplace Germany

16. Informant Charles Garrish
Address 11 Brightside ave. Pikesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/45 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18. Funeral director Frank H. Worrell
Address Pikesville, Maryland

19. 12-22-1945 (Date rec'd by registrar) Dr. E. E. Nichols M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1945 at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1930, to Dec 20 1945
and that I last saw her alive on Dec 20 1945

	DURATION
Immediate cause of death: Cerebral thrombosis	12 hours
Due to: Arteriosclerosis. —	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Egbert H. Worrell M.D. M. D. or other
Address 2706 St Paul St Date signed 12/21/45

RECEIVED
DEC 26 1945
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

11963

CERTIFICATE OF DEATH

★ Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Balto Co

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: 736 Frederick Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Walter Beall Grady

3. (b) Social Security Number 212-14-8123

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Louise M. Grady

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 15 1872

8. AGE: Years	Months	Days	If less than one day
73.	11		hrs. min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Contractor

FATHER 12. Name: Cyrus Grady

FATHER 13. Birthplace: Maryland.

MOTHER 14. Maiden name: Mary F. Beall

MOTHER 15. Birthplace: Maryland.

16. Informant: Louise M. Grady

Address: 736 Frederick Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10/45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Balto City

18. Funeral director: Edw. J. Mar Nabb

Address: Catonsville Md

19. 12-10 1945 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec, 6 19 45 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept, 20 19 45 to Dec, 6 19 45

and that I last saw him alive on Dec, 5, 19 45

Immediate cause of death	DURATION
Chr. Myocarditis.	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.:

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: 0 Date of:

Where did injury occur? 0 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) 0

Means of injury 0 Injured at work?

23. SIGNATURE: S. Lloyd Johnson M. D. or other

Address: Catonsville Date signed 12-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11960 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Mt. Pleasant Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 10 years
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 503 W yeth Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Charles Griffith

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband~~ or wife: Regina Griffith
6(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): September 26, 1900

8. AGE:

Years	Months	Days	If less than one day
45	3	3	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Meter Reader

11. Industry or business: Gas Co.

FATHER
12. Name: Allen Robert Griffith
13. Birthplace: U. S. A.

MOTHER
14. Maiden name: Margaret Jane Kinskiver
15. Birthplace: U. S. A.

16. Informant: Regina Griffith
Address: 503 W yeth Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/46 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frederick Ave.

18. Funeral director: Cambore, Inc.
Address: 4142 N. Franklintown Rd.

19. 1/2 (Date rec'd by registrar) 1946 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29, 1945, at 7 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1945, to Dec 29, 1945, and that I last saw him alive on Dec. 29, 1945

Immediate cause of death	DURATION
Myocardial Collapse	
Due to Pulmonary Tuberculosis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Albert J. Hiner M.D.
M. D. or other
Address: Reisterstown, Md. Date signed: Dec 29, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

CERTIFICATE OF DEATH

11965

★ Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
4 McHenry Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 McHenry Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emma C. Hagenrater

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 9, 1884

8. AGE: Years	Months	Days	If less than one day
61	2	23	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Henry C. Hagenrater
13. Birthplace: Md.

MOTHER
14. Maiden name: Katie —
15. Birthplace: Md

16. Informant: Mrs. Mary Kaufman
Address: 4 McHenry Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/45 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Randalstown Md.

18. Funeral director: Harry H. Weitze
Address: 4101 Edmondson Ave.

19. 12-3-45 (Date rec'd by registrar) 19 45 Dr. E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 19 45 at 10:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 19 45, to Dec 2 19 45, and that I last saw h.er alive on Dec 1st 19 45

	DURATION
Immediate cause of death: Heart Failure	24 Hrs.
Due to: Chronic Myocarditis	1 Yr or more.
Due to:	
Other conditions: Gall Stones	5 Yrs
Puerperal hemorrhagica (Include pregnancy within 3 months of death)	3 wks

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: E E Nichols Md
M. D. or other
Address: Pikesville 8 Md. Date signed 12-3-45

RECEIVED
DEC 5 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-E)

CERTIFICATE OF DEATH

11966

Reg. Dist. No. 33—

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural near Freeland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Baltimore.

City or town: Rural near Freeland.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: North of Freeland.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Louis Wetzel Hall.

3.(b) Social Security Number: 193-18-5944.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Minnie Hall

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): August 1, 1874.

8. AGE: Years	Months	Days	If less than one day
71	4	24	...hrs. ...min.

9. Birthplace: Warrington, Va. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Canning Factory.

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: "

16. Informant: Mrs. Minnie Hall.

Address: Freeland, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28, 1945. (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: 2930 Frederick Ave. Balto., Md.

18. Funeral director: J. Jacob Hartenstein

Address: New Freedom, Pa.

19. Dec 26 1945 (Date rec'd by registrar) Charles G. Fuller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25, 1945 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Dec 25 1945 and that I last saw him alive on Dec 24 1945

Immediate cause of death	DURATION
Bronchio-pneumonia	3 days
Due to	
Due to	
Other conditions: Arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. L. Bowers M. D. or other

Address: New Freedom, Pa. Date signed 12/26/45

RECEIVED
JAN 7 1946
BUREAU V.S.

Dr. Ed. Molz
7329 Harford Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

11967 P

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Prskville
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
33 Longmore Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prskville
City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 33 Longmore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hattie L. Hart

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W.

6.(b) Name of husband or wife: Charles W. Hart
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 9 - 1874

8. AGE: Years	Months	Days	If less than one day
71	-	21	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:
FATHER 12. Name: George Dreiling
13. Birthplace: Md.
MOTHER 14. Maiden name: Sarah Mussup
15. Birthplace: Md.
16. Informant: Mrs. Kohlhepp
Address: 33 Longmore Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-46 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto
18. Funeral director: Leonard J. Kuck
Address: 5305 Harford Road.
19. 1/2/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 - 1945 at 715 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 13 1945 to Dec 30 - 1945.
and that I last saw her alive on 27 Dec. 1945.

	DURATION
Immediate cause of death: Cerebrovascular accident (Apoplexy).	4 days.
Due to: Arteriosclerosis, generalized	10 yrs (?)
Due to: —	
Other conditions: Auricular fibrillation controlled by Digitalis. (Include pregnancy within 3 months of death)	1 wk.

Major findings of operations: None
Date of op.: —
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No. Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work? —

23. SIGNATURE: Edward L. J. Molz M.D.
M. D. or other
Address: 7329 Harford Rd. Balto 14 Md. Date signed: 31 Dec 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11968 44

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 36 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 N. Port St.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: JULIUS HEBBELL (HEBBEL)

3.(b) Social Security Number: 214-12-9434

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Rose Hebbell

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): 1-7-95

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
50	11	0		

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Inspector

11. Industry or business:

FATHER — 12. Name: Julius Hebbell

13. Birthplace: ?

MOTHER — 14. Maiden name: Bertha Algiers

15. Birthplace: ?

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10/45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Frederick Road.

18. Funeral director: Charles E. Lakemacher

Address: 2401-03 East Madison Street.

19. 12/10 19 45 (Date rec'd by registrar) A. M. Hebbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7, 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3, 1945, to December 7, 1945 and that I last saw him alive on December 7, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv. active III	6 Mos.
Due to	plus
Due to. Hurt left hip by twisting left lower extremity. Dec. 7.	
Other conditions Syphilis, tertiary, cerebro-spinal and Fracture neck of left femur	

(Include pregnancy within 3 months of death)

Major findings of operations: Not due to an accidental fall.

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT. COL., M.C. CLIN. DIR.

Address: Fort Howard, Md. Date signed: 12-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

8

11969 20

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or streel address where death occurred:
105 Melvin Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn iofants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest towo)
Streel No. 105 Melvin Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LAURA D. HECKMAN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles E. Heckman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1864

8. AGE: Years	Months	Days	If less than one day
81	8	28	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Joseph Raiber
13. Birthplace: Germany
MOTHER 14. Maiden name: Louise Halle
15. Birthplace: Germany
16. Informant: Mr. Lewis Kurtz, son-in-law
Address: 105 Melvin Ave., Catonsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/46 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
16. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 1/2 (Date rec'd by registrar) 19 46 A.O. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31 19 45 at 3:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/23 19 45 to 12/31 19 45 and that I last saw h.. alive on Dec 30 19 45

	DURATION
Immediate cause of death: Coronary Thrombosis	1 hr
Due to: Cardio Vascular Disease	18 Months
Due to:	
Other conditions:	

(Incinde pregnancy within 3 months of death)

Major fiadiogs of operations: ..... Date of op. .....
Aotopsy results:
PHYSICIAN: Please ooderlioe the caose to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Eliot W. Johnson M.D. M. D. or other
Address 3432 Greenmount Ave. Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11970

Reg. Dist. No. 9 38

1. PLACE OF DEATH:

County Baltimore

City or town Towson Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since March 28, 1943

Hospital, Institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since March 28, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 39 Eastship Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gertrude Heffner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Reginal Heffner

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) April 23, 1912

8. AGE: Years 33 | Months 7 | Days 25 | If less than one day ... hrs. ... min.

9. Birthplace Monessen Pa (Town, county, and state)

10. Usual occupation Housewife (R N)

11. Industry or business

FATHER 12. Name John G Santtari

13. Birthplace Finland

MOTHER 14. Maiden name Lidia Reens

15. Birthplace ~~Russia~~ Finland

16. Informant Personal History-Hospital Records

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 45 (month) (day) (year)

Cemetery or crematory Oak Lawn Cemetery

Location City

18. Funeral director Uellrich Funeral Home

Address 2008 O'Leans St

19. 12/18 1945 A. H. Uellrich Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1945 at 4.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1943, to Dec 18 1945 and that I last saw her alive on Dec 17 1945

Immediate cause of death Pulmonary Tuberculosis — DURATION: First noted Oct 1934

Due to — Second Dec 1937

Due to — Third Nov 1942

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE William A Bridges M. D. or other

Address Towson 4 Maryland — Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. [redacted]

FILM No. 100 JAN 11 1946

1. PLACE OF DEATH: Co. r

(a) Baltimore ~~City~~, Maryland

(b) Street address 4233 Belmar Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4233 Belmar Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. HEUERMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma V. Heuerman

6 (c) If alive, give age ~~1867~~ years

7. Birth date of deceased (mo., day, yr.) July 5, ~~1878~~

8. AGE: Years	Months	Days	If less than one day
78	5	1	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Retired General Service

11. Industry or business Gas & Elec. Co.

FATHER 12. Name William Heuerman

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Langhorn

15. Birthplace Germany

16 (a) Informant Mr. Luther Heuerman

(b) Address 3549 Chesterfield Ave.

17 (a) Burial (b) Date thereof 12/10/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 DEC 8 - 1945 Hunter for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1945, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945, to Dec 6 1945, and that I last saw h.. alive on Dec 5 1945.

Immediate cause of death	Duration
Coronary heart disease	6 months
Due to	
Due to	
Other Conditions Arteriosclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature A Lee Duncan M. D.

Address 1116 Northern Parkway Date signed 12/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

RECEIVED
DEC 11 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11972

Reg. Dist. No. 38 9

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Apr 23, 1945

Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since Apr 23, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2513 Lanvale Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Charles Edward Hofmann

3. (b) Social Security Number: 716-12-3754

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Jessie W. Hofmann

6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): October 12, 1874

8. AGE: Years: 71 | Months: 2 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Retired Engine man

11. Industry or business:

FATHER — 12. Name: George Hofman

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Reichardt

MOTHER — 15. Birthplace: Maryland

16. Informant: Personal History-Hospital Records

Address: Eudowood Sanatorium Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 3. 1946 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Baltimore Md

18. Funeral director: Thelom York Inc.

Address: 127 St Paul St

19. 1/2/46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 1945, at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1945, to December 31 1945

and that I last saw h-- alive on December 31 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	Diagnosed June 1945
Due to	
Due to	not well for 2½ years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William A. Bridges M. D. or other

Address: Towson 4 Maryland Date signed: 12-31-45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. [redacted] P

38 11973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto Co
(c) Hospital or institution: Armacost Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Overland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Philip Hotmeister

3 (b) If veteran, name war No.

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Augusta F.

6 (c) If alive, give age years

7. Birth date of deceaaed (mo., day, yr.) Oct. 12 1874

8. AGE: Years 71 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Philip Hotmeister
13. Birthplace Germany

MOTHER
14. Maiden Name Dorathea Bregel
15. Birthplace Balto

16 (a) Informant Harry Faulbrath
(b) Address Lombard & Ann St.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 12 6 45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Rd.

18 (a) Funeral director Mark W. E. Riggel
(b) Address 37 S. Ann St.
(c) [redacted] (Date received by registrar) Registrar

DEC 6 - 1945
12/6/45

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1945, at 2:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1942 to Dec. 4 1945, and that I last saw h[redacted] alive on Dec. 2 1945.

Immediate cause of death	Duration
Chronic myocardial degeneration	
Degenerative myocarditis	5 years
Due to Arteriosclerosis (cerebral)	
Due to Hypertension	
Other Conditions Cardiac decompensation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold, M. D.

Address 4706 Harford Road Date signed 12/5/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

11974

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto.
City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 Butler Road
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME: Katharine Gibson Hollingsworth

3.(b) Social Security Number: None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: Jessie Hollingsworth
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 11, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	27	..... hrs. ..... min.

9. Birthplace: Balto. City (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Frank Bandel
13. Birthplace: Balto. City
MOTHER 14. Maiden name: Georgia White
15. Birthplace: Md.
16. Informant: Mrs. W. A. Davis Jr.
Address: Glyndon, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11, 1945 (month) (day) (year)
Cemetery or crematory: Reisterstown Methodist
Location: Reisterstown, Md.
18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.
19. Dec - 11 - 1945 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 8 1945 at 12:10 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-10 1942 to 12-8 1945 and that I last saw h... alive on 12-7 1945

	DURATION
Immediate cause of death: Carcinoma of Breast	3 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. D. Caples, M.D. M. D. or other
Address Reisterstown, Md. Date signed 12-10-'45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 12 1945
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11975 P

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 1 month, 5 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 years, 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7126 Park Heights Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3. (a) FULL NAME Minnie A Holmes

3. (b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	married

6.(b) Name of husband or wife: Fred Holmes

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): April 13, 1882

8. AGE: Years	Months	Days	If less than one day
63	7	20	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: own home

FATHER
12. Name: Andrew Keller
13. Birthplace: Bavaria

MOTHER
14. Maiden name: Catherine Saltzman
15. Birthplace: Germany

16. Informant: Hospital records
Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-7-45 (month) (day) (year)

Cemetery or crematory: Maryland Park

Location: Baltimore

18. Funeral director: Leonard J. Buck

Address: 5305 Harford Rd.

19. 12/6/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3, 1945 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28, 1942, to Dec. 3, 1945 and that I last saw h... or alive on Dec. 3, 1945

Immediate cause of death	DURATION
Chronic myocarditis	Indef.
Due to:	
Due to:	
Other conditions: Atalectasis of the right lung (Include pregnancy within 3 months of death)	Indef.

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D. (M. D. or other)

Address: Baltimore - 28, Md. Date signed: 12/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11976

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County

City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Fort Howard Veterans Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 23 Bernice Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME Wm. J. HYNSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 2, 1896

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
49	8	22		

9. Birthplace: Elkton Cecil County, Md.
(Town, county, and state)

10. Usual occupation: Bartender

11. Industry or business: Duffys Tavern

FATHER 12. Name: Elmer E. Hynson

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Margaret B. Garrett

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. Raul A. Von Stofen

Address: North East Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-27-45 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore Maryland

18. Funeral director: George L. Schwab

Address: 2101 Frederick Avenue

19. 12/26/45 (Date rec'd by registrar) Alice Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/45 19 2:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/23/45 19 to 12/24/45 19

and that I last saw h[illegible] alive on 12/24/45 19

Immediate cause of death: Aleukemic Leukemia — DURATION: 1 mon.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard J. Abramovitz, Capt MC

M. D. or other

Address: Veterans Hospital, Fort Howard, Md. Date signed 12/24/45

11977

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (145)

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 29 Westminster Road
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Clara C. Johnson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

B.(b) Name of husband or wife Harvey E. Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1904

8. AGE: Years	Months	Days	If less than one day
41	3	28	..... hrs. ..... min.

9. Birthplace Balto. Co. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Hanson Jones
13. Birthplace Balto. Co.

MOTHER
14. Maiden name Frances Annie Burkett
15. Birthplace Balto. Co.

16. Informant Harvey E. Johnson
Address Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 24, 1945 (month) (day) (year)
Cemetery or crematory St. Lukes
Location Reisterstown, Balto. Co.

18. Funeral director J.F. Eline & Sons
Address Reisterstown, Md.

19. Dec 26 1945 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1945 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-20 1945, to 12-26 1945, and that I last saw her alive on 12-20 1945

Immediate cause of death	DURATION
Intra Abdominal Hemorrhage	7 hrs.
Due to Ruptured Uterus	7 hrs.
Due to Pregnancy	4½ mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Ruptured Uterus - Foetus in Abd.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. D. Eagles, M.D. medical Examiner
M. D. or other
Address Reisterstown Md. Date signed 12-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 26 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11978

P

1. PLACE OF DEATH:
County Bradshaw
City or town Balto Co Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford Co Md
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah E Johnson

3.(b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: George M. Johnson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1883
8. AGE: 62 Years | Months | Days | If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore Co Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name George Ames
13. Birthplace Md
MOTHER 14. Maiden name Sarah Bowens
15. Birthplace Md
16. Informant: George M Johnson
Address 317 Madison ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-23-45 (month) (day) (year)
Cemetery or crematory Mountain
Location Harford Co. Md.
18. Funeral director: Mrs Frances A Hemsley
Address 578 W Biddle St
19. 12/22/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945 at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7, 1943, to Dec. 19 1945
and that I last saw h.e alive on 20 Dec 18, 1945

	DURATION
Immediate cause of death: Bronchial pneumonia	2 day
Due to: Influenza	4 day
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Clifford T. Hudson, M.D.
M. D. or other
Address Fork Md. Date signed 12/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

11979

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville, Colonial Village

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Colonial Village

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4100 Colonial Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Samuel Wesley Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Jane Jones

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): March 6 - 1863

8. AGE: Years	Months	Days	If less than one day
82	9	14	... hrs. ... min.

9. Birthplace: Pennsylvania. (Town, county, and state)

10. Usual occupation: Retired, Contractor.

11. Industry or business:

FATHER — 12. Name: George Jones

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: —

MOTHER — 15. Birthplace: —

16. Informant: Mrs. Mary Jane Jones

Address: 4100 Colonial Rd. Pikesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/22/45 (month) (day) (year)

Cemetery or crematory: Westwood

Location: Downingtown, Pa

18. Funeral director: Frank H. Newell

Address: Pikesville, Maryland

19. 12-21-1945 (Date rec'd by registrar) Dr. E. E. Nichols MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/20 1945, at 1 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13th 1945, to Dec 20 1945, and that I last saw him alive on Dec 20 - 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	1 wk
Due to Arteriosclerosis	
Due to Arterial hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: E E Nichols MD (M. D. or other)

Address: Pikesville 8 Md Date signed 12-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 26 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

11980

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Annie Brooks Kelley

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Wm. H. Kelley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1858

8. AGE: Years	Months	Days	If less than one day
87	—	5	..... hrs. ..... min.

9. Birthplace: Belfast Balto Co, Md. (Town, county and state)

10. Usual occupation: Homemaker

11. Industry or business

FATHER

12. Name: Daniel B. Brooks

13. Birthplace: Balto. Co., Md.

MOTHER

14. Maiden name: Sallie Ensor

15. Birthplace: Balto. Co., Md.

16. Informant: Mrs. George P. Mays

Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 30 45 (month) (day) (year)

Cemetery or crematory: Bluds Rock

Location: Butler Balto Co. Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 12-29 19 45 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 28 1945, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1945, to Dec 28 1945

and that I last saw her alive on 12/27 1945

Immediate cause of death	DURATION
Myocardial Insufficiency	2 yrs.
(Pulmonary Edema)	
Due to: Arteriosclerosis	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wilmer C. Ensor M. D. (M. D. or other)

Address: Cockeysville Md. Date signed 12/29/45

RECEIVED
JAN 2 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

11981

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
14 W. Burke Avenue

How long in hospital or institution? ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 14 W. Burke Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3. (a) FULL NAME: PATRICK JOSEPH KELLY

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Delia A. Hughes Kelly

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): November 11, 1875

8. AGE: Years	Months	Days	If less than one day
70	1	3	....hrs. ....min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: Michael Kelly
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget Shannon
15. Birthplace: Ireland

16. Informant: Mrs. Delia A. Kelly

Address: 12 W. Burke Ave., Towson, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) Dec. (day) 17, (year) 1945

Cemetery or crematory: New Cathedral Cemetery

Location: Baltimore, Maryland

18. Funeral director: John Burns' Sons

Address: Towson, Maryland

19. (Date rec'd by registrar) 12/16 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 14, 1945, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19.... to 19....

and that I last saw h... alive on 19....

	DURATION
Immediate cause of death: Heart disease, muscular	1 day -
Coronary with occlusion	Unk
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Rollin E. Hudson M.D. D.M.E.
M. D. or other

Address: Towson 4 Md. Date signed 12/14/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 29 1945
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

11982 P

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town 321 Homberg Ave Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Balto

City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

Street No. 321 Homberg Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Kelmer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Henry Kelmer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19, 1857

8. AGE: Years	Months	Days	If less than one day
88	8	24	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Henry Freidlein

13. Birthplace Germany

MOTHER 14. Maiden name Eliza Falkenstein

15. Birthplace Germany

16. Informant Mrs. Mary E. Kelmer

Address 321 Homberg Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/17/45 (month) (day) (year)

Cemetery or crematory Western

Location Baltimore, Md.

18. Funeral director Wm. J. Tickner & Sons, Inc.

Address North & Pa. Aves. Baltimore Md.

19. 12/15 19 45 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 19 45, at 11 00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19 45, to Dec 13 19 45 and that I last saw h.. alive on Dec 13 19 45

Immediate cause of death	DURATION
Cardiac Decompensation	2 wk
Due to Hypertensive Heart Disease	5 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Emma Hohenemser M. D. or other

Address Essex Md Date signed 12/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (945)

CERTIFICATE OF DEATH

8

11983 35

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years, 6 months, 19 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 34 years, 6 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bay View Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war -- NO

3.(a) FULL NAME: John Lake

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1882 ?

8. AGE: Years	Months	Days	If less than one day
? 63			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation laborer

11. Industry or business bootblack, elevator boy

FATHER

12. Name John Lake

13. Birthplace Maryland

MOTHER

14. Maiden name Rebecca A. INLOSE

15. Birthplace Maryland

16. Informant Hospital Records

Address Catonsville, Baltimore - 28, Md.

17. Burial (Burial, ~~cremation~~, or removal: Which?) Date thereof 12/28/45 (month) (day) (year)

Cemetery or ~~crematory~~ Parkwood

Location Parkville Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

19. 12/27 (Date rec'd by registrar) 1945 H. W. Hedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1945 at 3:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1911, to Dec. 26, 1945 and that I last saw him alive on Dec. 26, 1945

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Arteriosclerosis of Coronary Arteries	[illegible]
Due to:	
Other conditions: Chronic Cystitis, Cause Undetermined	Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Isadore Tuerk

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Baltimore - 28, Md. Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93d) Reg. Dist. No. 4-4 11584

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Balto.
(b) City or town Govy (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 338 Stillwater Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Govy (If outside city or town limits, write RURAL and give town)
(d) Street No. 338 Stillwater Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Clara Marie Lang

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Lang.
6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 6 - 1892

8. AGE: Years 53 | Months 1 | Days 18 | If less than one day ____hr. ____min.

9. Birthplace Balto. Co. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name ? Rothenbucher

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name

MOTHER 15. Birthplace Germany

16 (a) Informant John Lang.
(b) Address 338 Stillwater Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Dayton, Md.

18 (a) Funeral director John G. Connelly
(b) Address 416 Eastern Ave. Edgs.

19 (a) 12/26/45 (Date rec'd by registrar) (b) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 23 1945, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1945, to Dec 23 1945, and that I last saw him alive on Dec 23 1945.

	Duration
Immediate cause of death Coronary Thrombosis	Sudden
Due to Arterio-Sclerotic Cardio-Vascular disease with Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. W. Baumgardner M. D. or other
Address Balto 6 Md Date signed 12-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 2 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11985

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
107 Shealey Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 107 Shealey Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Alfred Langdon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Laura A.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 3 1862

8. AGE: Years	Months	Days	If less than one day
83	9		hrs. min.

9. Birthplace: Baltimore CO. Md.
(Town, county, and state)
10. Usual occupation: Retired Agent
11. Industry or business: Sun Life Insurance Co.

FATHER
12. Name: Charles H. Langdon
13. Birthplace: Baltimore Co. Md.

MOTHER
14. Maiden name: Mary R. Wright
15. Birthplace: Baltimore Co. Md.

16. Informant: Mrs. Ruth Wallace
Address: 335 E. North Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/45 (month) (day) (year)
Cemetery or crematory: Western Cemetary
Location: Edmondson Ave.

18. Funeral director: Wm. J. Tickner & Sons
Address: North & Pa. Aves.

19. 12/17 19 45 P.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/14/ 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16th 19 45 to Dec 14th 19 45 and that I last saw h. alive on Dec 14th 19 45

Immediate cause of death	DURATION
Carcinoma of stomach	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Thos. Jenifer M. D. or other
Address: Towson 4, Md. Date signed: 12/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH Co.
(a) Baltimore ~~City~~, Maryland
(b) Street address Back River - Essex
(c) Hospital or institution: Balto. Co. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9026 Fountain Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Laws

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-5833?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business R. F. Foote Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Makowich Bro.
(b) Address Broadway Market

17 (a) Burial (b) Date thereof Dec. 28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Co. Cem.
Location Texas, Md.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Essex

19 (a) Dec 28 (b) 45 John G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1945, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Dissecting Aneurysm of Aorta.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skiteral M.D.
Medical Examiner.
Date signed December 5, 1945.

VS 151

RECEIVED
JUL 18
BUREAU OF

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

11987

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Lodge Forest

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2514 Lodge Forest Drive,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Lodge Forest,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2514 Lodge Forest Drive,

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Franklin Lee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Dorothy Lee nee Harris 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1912

8. AGE: Years	Months	Days	If less than one day
33	7		hrs. min.

9. Birthplace Johnston, Pa. (Town, county, and state)

10. Usual occupation -

11. Industry or business Beth. Steel

FATHER 12. Name James A. Lee

13. Birthplace Johnston Pa.

MOTHER 14. Maiden name Margaret Leightner

15. Birthplace Johnston Pa.

16. Informant Mrs. Dorothy Lee.

Address 2514 Lodge Forest Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/45 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave. Rd. Essex 21.

18. Funeral director John J. Connelly.

Address 418 Eastern Ave. Essex 21

19. 12/29/45 (Date rec'd by registrar) 19 45 John J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1945 at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 , to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Bullet wound thru upper Rt. Abdomen and	5 Mins.
Due to Pleura	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 12-27-45

Where did injury occur? Lodge Forest (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Gun by Policeman Injured at work? No

23. SIGNATURE [signature] M.D. or other

Address [illegible] Date signed 12/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

11988

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4619 Reisterstown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: TREVOR ALYWNN LEWIS

3.(b) Social Security Number: 214-03-1258

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Marie Lewis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16, 1893

8. AGE: Years	Months	Days	If less than one day
52	9	3	hrs. min.

9. Birthplace: South Wales, England
(Town, county, and state)

10. Usual occupation: Insurance agent

11. Industry or business

FATHER
12. Name: Samuel Lewis
13. Birthplace: England

MOTHER
14. Maiden name: Amelia Baker
15. Birthplace: England

16. Informant: Clinical Records, Vets. Adm.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-22-45 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Woodlawn Balto Co., Md.

18. Funeral director: Loring Byers.
Address: 5005 Park Heights Ave.

19. 12/20 1945 (Date rec'd by registrar) A.W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1945 at 12:09 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16, 1945 to December 19 1945 and that I last saw him alive on December 19 1945

	DURATION
Immediate cause of death: Hemorrhage, subarachnoid	4 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H.Y. RICHARDS, MAJOR, M.C. ACT. CLIN. DIRECT. M. D. or other
Veterans Administration
Address: Fort Howard, Md. Date signed 12-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11989

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore Co.

City or town: Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:
5501 Edmondson Ave
Road nursing

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Westview
(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 Westview Rd
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Hattie E Love.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed.

6.(b) Name of husband or wife: Michael Love

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 19 1876

8. AGE: Years	Months	Days	If less than one day
69			..... hrs. ..... min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Home wife

FATHER 12. Name: ?

13. Birthplace: Maryland.

MOTHER 14. Maiden name: ?

15. Birthplace: Maryland.

16. Informant: Margaret A Beasley

Address: 201 Westview Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/28/45 (month) (day) (year)

Cemetery or crematory: Greenlawn

Location: Baltimore City

18. Funeral director: Edw. S. MacNabb

Address: Catonsville Md

19. 12-28 1945 (Date rec'd by registrar) Harry D. Mullin Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1945 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to Dec 25 1945 and that I last saw h. alive on Dec 24 1945

Immediate cause of death	DURATION
Uremia	6 days
Due to: Chronic Interstitial nephritis	2 mo.
Due to: Diabetes mellitus	?
Other conditions: Gangrene (diabetic) of rt foot. (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. P. Van Schuylenburg M. D. or other

Address: 4818 Edmondson Ave Date signed: 12/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dec 19 1874

Def re. Rec. Cyphers to Lead Nursing Home 1/9/46 dk

RECEIVED
JAN 2 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

11990

Reg. Diat. No. 31

1. PLACE OF DEATH:

County Baltimore

City or town Granite
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Baltimore

City or town Granite
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter Wesley Lynn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of husband or wife Margaret Lynn

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60	*	*	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Margaret Lynn
Address Granite, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-13-45 (month) (day) (year)

Cemetery or crematory Cherry Hill

Location Granite, Md

18. Funeral director F.C. Higinbothom

Address Ellicott City, Md.

19. Dec 10, 1945 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10-45 19 at 10.40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 40 to Dec. 10, 19 45

and that I last saw h alive on Dec. 9, 19 45

Immediate cause of death	DURATION
Chronic Valvular Heart Disease	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Date signed Dec 10 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 20 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11991

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 40 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residsnes of mother)

State: Maryland County:

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Maffitt Street
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME

JOHN H. MAJOR

3.(b) Social Securily Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 2, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	27	hrs. min.

9. Birthplace: Elkton, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Emmanuel Major
13. Birthplace: England

MOTHER
14. Maiden name: Emma Roff
15. Birthplace: New Jersey

16. Informant: Clinical Records

Address: Vets.Adm.Hosp.Ft.Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 2 1946 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton

18. Funeral director: H. W. Pippin & Son

Address: Elkton Md.

19. Dec. 29 19 45 John H. Connelly Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 19 45 at 9:05A M

21. I CERTIFY that death occurred on ths date above stated; that I allended deceased from November 20 19 45, to December 29 19 45

and that I last saw h im alive on December 29 19 45

	DURATION
Immediate canse of death: Bronchogenic Carcinoma, rt. lung	
Due to:	
Due to:	
Other conditions:	

(Include pregnaney within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the canse to which death should be charged statistically.

22. VIOLENCE: If death wae due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. M. BALTER, LT. COL., M.C. M. D. or other

CLINICAL DIRECTOR

Address: Fort Howard, Md. Date signed 12/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 3 1946
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1006 Essex Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: John P. Maldeis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Sigrist
6.(c) If alive, give age: (D) years

7. Birth date of deceased (mo., day, yr.): May 11th, 1882

8. AGE: Years	Months	Days	If less than one day
63	7	3	...hrs. ...min.

9. Birthplace: Baltimore County (Town, county, and state)
10. Usual occupation: Retired brakeman
11. Industry or business: Back River & Patapsco R.R.

FATHER
12. Name: Herman Maldeis
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Miss. Catherine Maldeis (Daughter)
Address: 1006 Essex Avenue, Balto: Co

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/17/45 (month) (day) (year)
Cemetery or crematory: Oaklawn Cemetery
Location: Eastern Avenue

18. Funeral director: George J. Ruth, Inc.
Address: 1735 Harford Avenue

19. 12/15 (Date rec'd by registrar) 19 45 A. Wiltbrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14th, 19 45 at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 45 to Dec 14 19 45 and that I last saw h... alive on Dec 14 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to Arteri-Sclerotic cardio-Vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Leo M. Baumgardner M. D. or other
Address: Balto 6 Md Date signed 12-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

11993

CERTIFICATE OF DEATH ★ Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 129 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
How long in hospital or institution? 129 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Glencoe
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: SAW RETIRED

3.(a) FULL NAME: FRANKLIN MARTIN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1857

8. AGE: Years	Months	Days	If less than one day
88	5	~~28~~ 23	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Charles Martin
13. Birthplace: Maryland

MOTHER
14. Maiden name: Racheal Goodwin
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-12-45 (month) (day) (year)
Cemetery or crematory: Hereford Baptist
Location: Moyton, Md.

18. Funeral director: J. Scott Brooks
Address: Sparks, Md.

19. Dec 11 1945 (Date rec'd by registrar) Dawson L. Faber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1945 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1945 to Dec. 12 1945 and that I last saw him alive on December 12, 1945

Immediate cause of death	DURATION
Disease of the Heart	unknown
Due to: Hypertension and coronary arterio-sclerosis, myocardial insufficiency, auricular fibrillation	
Due to:	
Other conditions: Cerebral hemorrhage	4 mos.
Hemiplegia, left	4 mos.
Bronchopneumonia (Include pregnancy within 3 months of death)	9 days

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter A.M. BALTER, LT. COL. M.C. CLIN. DIR. M. D. or other
Address: Vet. Adm. Fort Howard, Md. Date signed: 12-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
DEC 15 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

11994 48

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Balto Co.
City or town: Baldwin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Baldwin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Mast

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 10 - 1873

8. AGE: Years 72 | Months 5 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Henry Mast
13. Birthplace: Md.

MOTHER
14. Maiden name: Barbara Moyer
15. Birthplace: Md.

16. Informant: Wm. Henry Mast
Address: Hyde Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 28-45 (month) (day) (year)
Cemetery or crematory: Chestnut Grove Cem.
Location: Sweet Air Md.

18. Funeral director: Clarence E. Arthur
Address: Fork Md.

19. Dec. 26 1945 (Date rec'd by registrar) C. E. Arthur Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 8, 1941 to Dec. 25 1945 and that I last saw h... alive on Dec 24 1945.

	DURATION
Immediate cause of death: Rupture of Esophageal Varix	2 days
Due to: Arteriosclerotic Heart Disease with De-	1 yr.
Due to: Compensation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D.
M. D. or other
Address: Fork, Md. Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 2 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

11995

★ Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Balto
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 hrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. Towson York Rd. 1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Margaret Anne Matthews

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C	Married

6.(b) Name of husband or wife: Joseph L. Matthews
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): Oct. 2nd 1877

8. AGE:

Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace: Cockeysville Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Alfred Johnson
13. Birthplace: Md.
MOTHER 14. Maiden name: Margaret E.
15. Birthplace: Md.
16. Informant: Joseph L. Matthews
Address: York Rd N. Towson Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-23-45 (month) (day) (year)
Cemetery or crematory: Pleasant Rest Cem.
Location: Towson Md.
18. Funeral director: Byron Mamie W. Wright
Address: 721 Eutaw St. Balto. Md.
19. Dec. 22 19 45 (Date rec'd by registrar) Maxwell Carlson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 19 45 at 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Heart Disease, Chronic myocarditis with decompensation — DURATION: 12 yrs
Due to: Hypertension — DURATION:
Due to: Arteriosclerosis — DURATION: Unk.
Other conditions: Chronic varicose ulcer, rt. leg. — DURATION: 28 yrs
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rollin L. Hudson M.D. D.M.E.
M. D. or other
Address: Towson 4 Md. Date signed 12/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 29 1945
BUREAU V.R.

11996

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

Reg. Diat. No. 44.

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk (Gray Manor)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All life in Balto Co.
Hospital, Institution, or street address where death occurred:
32 Lombardy Dr.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Dundalk, r.f.d. Gray Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 32 Lombardy Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Anthony Charles Mayewski.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1945

8. AGE: Years | Months | Days: 1 | If less than one day: 7 hrs. ..... min.

9. Birthplace: Balto. Co. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Anthony Mayewski
13. Birthplace: Balto Md

MOTHER
14. Maiden name: Katherine Sadler
15. Birthplace: N. Y.

16. Informant: Anthony Mayewski
Address: 32 Lombardy Dr.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12 4 45 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary
Location: Balto Co. Md

18. Funeral director: James J. Brudzinski
Address: 4107 Eastern Ave Rd

19. Dec. 4 1945 (Date rec'd by registrar) John H. Cowell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 3 1945, at 5:25 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Due to: Prematurity	about 7 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. McCarmine M.D.
M.D. or other
Address: Dundalk Md Date signed 12/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(C) (M)

RECEIVED
DEC 8 1945
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11997 44

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: # 3 Open Hearth Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 36 Kinship Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Morrison Henry McGowan

3.(b) Social Security Number: 213-09-0571

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Irene L. Mc Gowan
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1880

8. AGE: Years	Months	Days	If less than one day
65	2	5	hrs. min.

9. Birthplace: Trenton N. J. (Town, county, and state)
10. Usual occupation: Steel Worker
11. Industry or business: Bethlehem Steel
12. FATHER — Name: Michael Henry Mc Gowan
13. FATHER — Birthplace: Trenton N. J.
14. MOTHER — Maiden name: Laura Pittinger
15. MOTHER — Birthplace: Jobestown N. J.
16. Informant: Mrs Irene L. Mc Gowan
Address: 36 Kinship Rd. Dundalk Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 17 1945 (month) (day) (year)
Cemetery or crematory: St. Johns Cemetery
Location: Ellicott City, Md.
18. Funeral director: Easton Sons
Address: 608 Frederick Ave, Catons Md.
19. Dec. 15 1945 (Date rec'd by registrar) Dawson L. Harbold Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1945, at 2 45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: J. M. Carmine M.D. M. D. or other
Address: Dept. Medical Dundalk Md. Date signed 12/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 18 1945
BUREAU V-M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11398 P

Reg. Dist. No. 3 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Riderwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Riderwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine McHale

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
abt 72	—	—	hrs. min.

9. Birthplace Md - Va

(Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business

FATHER 12. Name Patrick McHale

13. Birthplace Ireland

MOTHER 14. Maiden name Mary Fahey

15. Birthplace Ireland

16. Informant Mr. Thos. J. Harrington

Address Riderwood

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/6/45 (month) (day) (year)

Cemetery or crematory Monte Marie

Location Towson

18. Funeral director J. J. Fahey & Son

Address 1308 Light St

19. 12/3 19 45 Mabel Dyer Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 19 45, at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 42, to 12-3 19 45

and that I last saw her alive on Dec 3, 19 45

Immediate cause of death	DURATION
Pulmonary Edema	12-3-45
Due to Pneumonia, Bronchial	11/27/45
Due to Arteriosclerosis, Cerebral & General	3 yrs
Other conditions	Unk

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bennett A Sears M. D. or other

Address Lutherville, Md Date signed 12/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

11999

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town 3012 Ritchie Ave. Sparrows Point - 19
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Edgemere
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3012 Ritchie Ave
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME GEORGE H. MCKINNEY

3. (b) Social Security Number

4. Sex MALE
5. Color or race WHITE
6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife EDITH ANNA MOORE
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) MAY 22, 1890

8. AGE:	Years	Months	Days	If less than one day
	55	6	16	... hrs. ... min.

9. Birthplace AUGUSTA, GA. (Town, county, and state)
10. Usual occupation YARD MASTER
11. Industry or business P & B R.R. Co.

FATHER
12. Name William H. McKinney
13. Birthplace Georgia

MOTHER
14. Maiden name Mary J. Shirer
15. Birthplace Georgia

16. Informant Elwood F. McKinney
Address 3012 Ritchie Ave, Edgemere, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11, 1945 (month) (day) (year)
Cemetery or crematory Oaklawn Cemetery
Location Baltimore, Md.

18. Funeral director WILLIAM J. TICKNER AND SONS.
Address NO. AND PA. AVES. BALTIMORE, 17, MD.

19. Dec 9 1945 Dawson L. Harber, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 8, 1945 19... at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 1942 to Dec 8 1945
and that I last saw him alive on Dec 8 1945

		DURATION
Immediate cause of death	Coronary Occlusion	sudden
Due to	Myocardial degeneration	two ½ years
Due to	Arterio sclerosis	three years
Other conditions (Include pregnancy within 3 months of death)	Occlusion of one of Vessels supplying lateral aspects of spinal cord. Partial paralysis of rt. side	2½ years

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dawson L. Harber M. D. or other
Address Sparrows Point 19 Md Date signed 12/9/45

VS-A15

(I)

RECEIVED
DEC 11 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 12-30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Halbrook (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, Institution, or street address where death occurred: Owings Mills P.O.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Halbrook (If outside city or town limits, write RURAL and give nearest town)

Street No.: Owings Mills P.O. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert H. McLane

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1 1885

8. AGE: Years: 60 Months: 5 Days: 5 If less than one day: hrs. min.

9. Birthplace: Laborer (Town, county, and state)

10. Usual occupation: Md.

11. Industry or business

FATHER 12. Name: John McLane

13. Birthplace: Md.

MOTHER 14. Maiden name: Amelia Fedkay

15. Birthplace: N.C.

16. Informant: Miss. Mary J. McLane

Address: 217 N. Eugene Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 7-1945 (month) (day) (year)

Cemetery or crematory: Hardis Chapel

Location: Balto. Co.

18. Funeral director: Harry Kerr

Address: Sykesville, Md.

19. 12/5/1945 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5, 1945 10:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20, 1945, to Dec. 5, 1945

and that I last saw him alive on Dec. 4 1945

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Myocarditis	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Date signed: 12/7/45

RECEIVED
DEC 8 1945
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-a)

CERTIFICATE OF DEATH

12001P

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Ruxton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ga. County: Savannah

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 E. 3rd St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Eulalie Swinton Mc Leod

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Harry Augustus

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 25th 1866

8. AGE: Years	Months	Days	If less than one day
79	10	8	..... hrs. ..... min.

9. Birthplace: Williamston Springs So. Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Hugh Ralth Swinton
13. Birthplace: S.C.

MOTHER
14. Maiden name: Martha Vincent
15. Birthplace: S. C.

16. Informant: Mrs. John Mc. Fall
Address: Ruxton Md.

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof 12/3/45
(month) (day) (year)

Cemetery or crematory: Savannah Ga.

Location

18. Funeral director: William J. Tickner & Sons
Address: North & Pennsylvania Aves

19. 12/3 19 45 C W Hedgepeth
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 19 45 at 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26 45 to December 2 19 45
and that I last saw h. 45 alive on December 2, 19 45

Immediate cause of death	DURATION
Apoplexy	8 days
Due to: Arterio Sclerosis + Hypertension	Unk.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John S. Green Jr. M. D. or other

Address: Lawson - Md Date signed 12/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

12002 42

Reg. Dist. No.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: 4 years

Hospital, institution, or street address where death occurred: 1306 Stevens Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1306 Stevens Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Anna Meyers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Elmer Frank Meyers

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 5, 1917

8. AGE: Years	Months	Days	If less than one day
28	1	15	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Theodore Wallega

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden name: Mary Patryk

MOTHER — 15. Birthplace: Poland

16. Informant: Elmer Frank Meyers

Address: 1306 Stevens Ave. Arbutus

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-45 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Baltimore, Maryland

18. Funeral director: George L. Schwab

Address: 2101 Frederick Ave. Balto, Md.

19. Dec 31 1945 (Date rec'd by registrar) G. McKeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20, 1945 19 at about 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Suicide	
Due to: Strangulation	
Due to: Hanging from	
Other conditions: Cellar Ceiling	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of Dec 23 45

Where did injury occur? Arbutus (City or town) Balto Co (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Hanging from cellar ceiling Injured at work? No

23. SIGNATURE: Geo McKeffer Dep Coroner Balto Co

M. D. or other

Address: 1010 Leeds Date signed 12-26-45

RECEIVED
DEC 28 1945
BUREAU V A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

12003 Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3601 Lucille Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Meyers

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October(?) ? 1885

8. AGE: Years	Months	Days	If less than one day
60	?	?	hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Boilermaker

11. Industry or business: Maryland Dry Dock

FATHER 12. Name: Abraham ?

13. Birthplace: Russia

MOTHER 14. Maiden name: Jennie Kretzman

15. Birthplace: Russia

16. Informant: Hospital Records

Address: Catonsville 28 Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 17/45 (month) (day) (year)

Cemetery or crematory: Baltimore Md

Location: Plot

18. Funeral director: Sol Levinson & Bro

Address: 1124-26 W Baltimore

19. 12/15 19 45 (Date rec'd by registrar) Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15, 1945, at 5:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10, 1945, to December 15 1945 and that I last saw him alive on December 15, 1945

Immediate cause of death	DURATION
Myocardial insufficiency	indef.
Due to: Arteriosclerotic cardiovascular-renal disease	indef.
Other conditions: Pulmonary oedema	5 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: S. W. Weltmer, M.D. M. D. or other

Address: Spring Grove State Hospital Date signed: 12-15-45

RECEIVED
DEC 18 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

12064 30
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 4 Wade Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 Wade Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Frank F Middlecamp

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife: Mabel S Middlecamp
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 18 1888

8. AGE: Years	Months	Days	If less than one day
57	2	23	hrs. min.

9. Birthplace: Catonsville Md (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: B & O R R

FATHER
12. Name: Henry Middlecamp
13. Birthplace: Md

MOTHER
14. Maiden name: Virginia McDonald
15. Birthplace: Md

16. Informant: Mrs F F Middlecamp
Address: 4 Wade Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-15-45 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore Md
18. Funeral director: George A Tyler
Address: Fulton Lemmon Fayette St.

19. 12-14 1945 (Date rec'd by registrar) Harold L Mullen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-11 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 1944, to Dec 11 1945
and that I last saw h[illegible] alive on Dec 11 1945

Immediate cause of death: Coronary Embolism — DURATION: 1 hr.
Due to: Auricular Fibrillation — 2 mos.
Due to: Cardio-Vascular-Disease — 2 yrs?
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hoag V Gilbert M.D. M. D. or other
Address: 882 32nd Ave Catonsville 28 Md Date signed: 12-12-45

DEC 18 1945
BUREAU V.R.

Evidence for change of birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

12005

Reg. Dist. No. 32

FILM No. 100 JAN 8 1946

1. PLACE OF DEATH:
County Balto.
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, institution, or~~ street address where death occurred: 7023 Alden Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7023 Alden Rd
(If rural, give LOCATION)
2.(a) If veteran, name war W

3.(a) FULL NAME Helena Minder

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Henry Minder
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 8th 1873

8. AGE: Years	Months	Days	If less than one day
72	0	9	..... hrs. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
FATHER 12. Name Justus Mueller
13. Birthplace Germany
MOTHER 14. Maiden name Wilhelmia Hamell
15. Birthplace Germany
16. Informant Mrs Helene M. Haynie
Address 7023 Alden Rd - Pikesville Md
17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 12/19/45 (month) (day) (year)
Cemetery or ~~crematory~~ Oak Lawn
Location Eastern Ave. Extended
18. Funeral director William Cook Inc
Address 1217 St. Paul St
19. 12/18/45 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17th 1945 at 3:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17, 1945 to December 17, 1945 and that I last saw her alive on December 15, 1945

	DURATION
Immediate cause of death Coronary insufficiency	? yrs.
Due to	
Due to	
Other conditions Chronic cholecystitis.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Edwin B. Jaretti M. D. or other
Address 11 E. Chase St., City. Date signed 12/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

12006 P.

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2142 Aiken St (If rural, give LOCATION)

2.(a) If veteran, name war N/A

3.(a) FULL NAME Augusta Meskill

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

B.(b) Name of husband or wife John C.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 24, 1874

8. AGE: Years	Months	Days	If less than one day
71	4	20	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Andrew Stadler

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Germany

16. Informant Anna Baird

Address 2142 Aiken St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/19/45 (month) (day) (year)

Cemetery or crematory Holy Cross

Location Baltimore Md

16. Funeral director Wilson Funeral Home

Address 1214 E Fort Ave

19. 12/17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1945, at 3:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1945 to Dec 14 1945

and that I last saw her alive on Dec 14 1945

Immediate cause of death	DURATION
Carcinomatous pulmonary oedema	2 days
Due to Chronic myocardial disease	3 yrs.
Due to	
Other conditions Chronic interstitial nephritis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A Lee Hitchens M. D. or other

Address 4116 Northern Parkway Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

*12007

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 9117 Harford Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Parkville (If outside city or town limits, write RURAL and give nearest town)

Street No. 3023 Acton Road Parkville (If rural, give LOCATION) Balto. 14

2.(a) If veteran, name war

3.(a) FULL NAME Charles L Mott

3.(b) Social Security Number 216-24-0024

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife Hattie A. Mott

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 19th 1879

8. AGE: Years	Months	Days	If less than one day
66	1	28	....hrs. ....min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation Sightseer

11. Industry or business Fuel Oil delivery

FATHER 12. Name Joseph Mott

FATHER 13. Birthplace Pennsylvania

MOTHER 14. Maiden name Augusta Michael

MOTHER 15. Birthplace Unknown

16. Informant Mrs. Joseph L. Mott

Address 2918 Chinook Ave. Parkville

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 12/20/1945 (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore, Maryland

18. Funeral director Lawrason Funeral Home

Address 7491 Belair Road

19. 12/18/45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945 at 2.05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw h... alive on ..... 19....

Immediate cause of death Heart disease Chronic, vascular, coronary, with occlusion — DURATION: Dec 17, 1945

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings at operation.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Rollin G. Hudson M.D. M. D. or other

Address Towson 4 Md Date signed 12/17/45.

RECEIVED
JAN 2 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12008

Reg. Dist. No. 33

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Balto.

City or town Rural Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Rural Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Laura Edith Tinkler Murray

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Wd.

6.(b) Name of husband or wife John G. Murray

6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1875

8. AGE: Years	Months	Days	If less than one day
69	4	13	hrs. min.

9. Birthplace Deer Park, Balto. Md.

(Town, county, and state)

10. Usual occupation House-wife

11. Industry or business

FATHER 12. Name Tinkler

13. Birthplace unknown

MOTHER 14. Maiden name Katherine Wormsall

15. Birthplace Balto.

16. Informant Marjorie J. Colwell

Address Reisterstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 27, 1945 (month) (day) (year)

Cemetery or crematory Deer Park

Location near Reisterstown

18. Funeral director Wm. Berryman

Address Reisterstown

19. 12-26 1945 (Date rec'd by registrar) Mary B. Kline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1945 to Dec 24 1945 and that I last saw her alive on Dec 23 1945

Immediate cause of death	DURATION
Lobar Pneumonia	5 da.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, M.D. M. D. or other

Address Reisterstown, Md. Date signed 12-26-45

RECEIVED
DEC 28 1945
BUREAU V S

Maryland State Dept of Health

~~BALTIMORE CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 32

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Summit ave, Granite Md
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Granite, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. SUMMIT AVE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Henry ~~Jimmy~~ MURRAY

3 (b) If veteran, name war: NO
(c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	

6 (b) Name of husband or wife: Mary Ellen Murray nee Bontell
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 12/28/1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	11	16		

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Stone cutter - Retired
11. Industry or business

FATHER
12. Name Joseph Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Donnelly
15. Birthplace Ireland

16 (a) Informant Raymond Murray
(b) Address Granite md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18-1945 (month) (day) (year)
(c) Cemetery or crematory ST. ALPHONSUS -
Location Church Cemetery - Woodstock

18 (a) Funeral director J. C. Heggenbottom
(b) Address Ellicott City, Md.

19 (a) 12-17-45 (Date rec'd by registrar) (b) E. E. Nichols MW Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1945, at 8.46 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1944 to Dec 14 1945 and that I last saw h[illegible] alive on Dec 12 1945

Immediate cause of death	Duration
Chronic Myocarditis,	2 yrs
Due to arterio Sclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. E. Nichols M. D.
Address Ellicott City Md Date signed 12-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

DEC 20 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

12010

Reg. Diat. No. 41

P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
85 Kinship Rd.
How long in hospital or institution? 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 85 Kinship Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Virginia Nagle.

3. (b) Social Security Number

4. Sex: Fem.
5. Color or race: White.
6.(a) Single, married, widowed, or divorced: Widow.
6.(b) Name of husband or wife: Chas D.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Feby 4 / 1880
8. AGE: Years 65 | Months 10 | Days 15 | If less than one day ..... hrs. ..... min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Nurse
11. Industry or business
FATHER 12. Name Wm. J. Glover
13. Birthplace Baltimore Md.
MOTHER 14. Maiden name Marta Thomas.
15. Birthplace Baltimore Md.
16. Informant Henry G. Nagle.
Address 85 Kinship Rd. Dundalk Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/45 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location 7225 Eastern ave
18. Funeral director Clarence F. Hofmann
Address 1639 n Broadway
19. (Date rec'd by registrar) Dec 26 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945 at 6 25 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 11 1945 to Dec 19 1945
and that I last saw h alive on Dec 19 1945

	DURATION
Immediate cause of death Acute Myocarditis	1 hr.
Due to	
Due to	
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. B. Davis M.D.
M. D. or other
Address Dundalk Md Date signed 12/26/45

12611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16402)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7½ hours

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 7½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Reisterstown (If outside city or town limits, write RURAL and give nearest town)

Street No. ? (If rural, give LOCATION)

2.(a) If veteran, name war --

3. (a) FULL NAME W. Grant Naylor

3. (b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife: Lida Combs

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 10, 1867

8. AGE: Years	Months	Days	If less than one day
78	9	8	... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: carpenter

11. Industry or business: carpentry

FATHER 12. Name: Levy Naylor

13. Birthplace: Maryland

MOTHER 14. Maiden name: Rebecca Russell

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 20 '45 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown

19. 12/27 1945 (Date rec'd by registrar) Harry W. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18, 1945, at 12:30 Am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to: Chron Myocarditis	
Due to: Suicide due to shock, loss of blood, cutting vessels neck & wrists	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: Dec 18. 45

Where did injury occur? Reisterstown (City or town) Balt Co (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury: cut wrists & vessels of neck by razor blade Injured at work? no

23. SIGNATURE: Geo McKieffer Dep Med Exam of Balto Co M. D. or other

Address: 1010 Leeds ave Date signed 12/18/45

RECEIVED
DEC 28 1945
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12012

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Catonsville Home

Hospital, institution, or street address where death occurred: Inglesside & Edmondson Ave.

How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Talbot

City or town: Easton (If outside city or town limits, write RURAL and give nearest town)

Street No. Easton (If rural, give LOCATION)

2.(a) If veteran, name war: ?

3. (a) FULL NAME: Henry Newton

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mrs. Henry Newton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): abt 1866

8. AGE: Years	Months	Days	If less than one day
abt 79			hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Retired

FATHER — 12. Name: Not Known

FATHER — 13. Birthplace: Not Known

MOTHER — 14. Maiden name: Not Known

MOTHER — 15. Birthplace: Not Known

16. Informant: Records of Catonsville Home

Address: Inglesside & Edmondson Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3/46 (month) (day) (year)

Cemetery or crematory: Springhill Cemetery

Location: Easton, Md.

18. Funeral director: L. Stewart & Mowen Company

Address: 108 W. North Ave, Balto. City.

19. 1-2 1946 (Date rec'd by registrar) Harry E. Mullen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1945 at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1941 to Dec 31 1945

and that I last saw h... alive on Dec 30 1945

Immediate cause of death	DURATION
Bronchial pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Edmondson Ave Date signed 1/2/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 8 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12013

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 9 mos., 0 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 9 mos., 0 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington Co.
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 425 Jefferson Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Iris S. Niswander

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 2, 1920

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
25	9	4		

9. Birthplace: Hagerstown, Maryland (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business:

FATHER
12. Name: Samuel K. Welch
13. Birthplace: Hories, Maryland

MOTHER
14. Maiden name: Mary E. Williams
15. Birthplace: Pennsylvania

16. Informant: Mrs. Iris S. Niswander
Address: 425 Jefferson St., Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: Suter & Son
Address: 301 N. Potomac St., Hagerstown, Md.

19. Dec. 6, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6, 1945 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1944 to Dec. 6, 1945 and that I last saw her alive on December 6, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2½ yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Syphilis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D.
M. D. or other
Address: Mount Wilson, Md. Date signed: 12/6/45

Rec'd by Dr E E Nichols 12-8-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
DEC 10 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

P

12014

Reg. Dist. No.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Balto.

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3020 Taylor Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Virginia Norris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W.

6.(b) Name of husband or wife: Clinton C.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 11-1852

8. AGE: Years: 93 Months: 2 Days: 10 If less than one day: hrs. min.

9. Birthplace: Balto

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER 12. Name: Frederick Harrison

13. Birthplace: Balto

MOTHER 14. Maiden name: Sarah Frederick

15. Birthplace: Balto

16. Informant: Mrs Elsie V Heathcock

Address: 3020 Taylor Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/45 (month) (day) (year)

Cemetery or crematory: London Pk.

Location: Balto. Md.

18. Funeral director: Wm Cook Inc

Address: 217 St Paul St

19. 12/22 19 45 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21-45 19 at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 19 45 to Dec 21 19 45 and that I last saw h[illegible] alive on Dec 20 19 45

Immediate cause of death	DURATION
Uremia	Dec-19/45
Chronic nephritis	Jun/1943
Due to: arterio & chron arterial hypertension	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Louis J. Krumrein M. D. or other

Address: 722 N. Kenwood Ave Date signed: 12/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12015

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ~~Harford~~ Balto
City or town Glen Arm Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County ~~Harford~~ Balto
City or town Glen Arm
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Joseph OHLER

3.(b) Social Security Number

4. Sex: Male
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary Elizabeth Callahan
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov. 25 1883
8. AGE: Years: 62 Months: Days: If less than one day: ..... hrs. ..... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Ord Master
11. Industry or business:
FATHER 12. Name: James J. Ohler
FATHER 13. Birthplace: Md
MOTHER 14. Maiden name: Mary Kolan
MOTHER 15. Birthplace: Ireland
16. Informant: Mrs. James Ohler
Address: Glen Arm Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-17-45 (month) (day) (year)
Cemetery ~~or crematory~~ St Johns
Location Long Green Md
18. Funeral director: Henkenyer & Gross
Address Bel Air, Md.
19. 12/14/45 W H Hammett Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 13 19 45 at 9:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 19 45 to Dec 13 19 45 and that I last saw h[illegible] alive on Dec 13 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 day
Due to Lobar-Pneumonia	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter W Hammett M. D. or other
Address Baldwin Date signed 12/14/45

RECEIVED
DEC 20 1945
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

12016 P.

Reg. Dist. No. 4K

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1722 Belt St. (If rural, give LOCATION)

2.(a) If veteran, name war: WW

3. (a) FULL NAME: WILLIAM O'MELIA

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1891

8. AGE: Years	Months	Days	If less than one day
54	7	5	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER — 12. Name: Patrick O'Melia

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Mary Goulton

15. Birthplace: Ireland

16. Informant: Clinical Records, Vets. Adm.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 15 45 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial Cemetery

Location: ~~5601 Reed Rd. Md.~~ Annapolis R.D., Baltimore, Md.

18. Funeral director: A. Lee Oder

Address: 4644 York Rd. Balto. Md.

19. (Date rec'd by registrar) 12/14 1945 A.W. Hedrick, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1945, at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8 1945 to December 11 1945 and that I last saw him alive on December 11 1945

	DURATION
Immediate cause of death: Pneumonia, lobular	5 days
Due to:	
Due to:	
Other conditions: Atelectasis, Rt. base	5 days
Alcoholism, chronic	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. BALTER, LT. COL., M.C. Clin. Dir. M. D. or other

Address: Vets. Adm. Ft. Howard, Md. Date signed: 12-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Dr. Grott

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

12017

Reg. Dist. No. 37

1. PLACE OF DEATH:
County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
7809 Wilson Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7809 Wilson Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George William Padgett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Emma Padgett
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1869

8. AGE: Years	Months	Days	If less than one day
76	6	7	hrs. min.

9. Birthplace Hughesville, Maryland (Town, county, and state)
10. Usual occupation Retied
11. Industry or business

FATHER 12. Name Joseph Padgett
13. Birthplace Maryland

MOTHER 14. Maiden name Mary Ann Smith
15. Birthplace Maryland

16. Informant Mrs. Katherine De Vries
Address 7809 Wilson Avenue -14-

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/45 (month) (day) (year)
Cemetery or crematory Parkwood
Location Baltimore

18. Funeral director Leonard J. Ruck
Address 5305 Harford Road -14-

19. 12/3/45 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st, 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/30 1945 to 12/1 1945 and that I last saw h alive on 12/1 1945

Immediate cause of death	DURATION
Uremia	2d.
Due to arteriosclerotic cardiovascular renal disease	3 y.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. A. Grott, M.D. M.D. or other
Address 8100 Harford Rd Date signed 12/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 1203 12

1. PLACE OF DEATH:

County: Baltimore

City or town: Stevenson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Stevenson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: EMMA J. PARSLEY

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Wm. T. Parsley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
about 70			..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Jesse Wheat

13. Birthplace: ?

MOTHER — 14. Maiden name: Margaret Fishpaw

15. Birthplace: ?

16. Informant: Mr. William T. Parsley

Address: Stevenson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/7/45 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 12-6-45 (Date rec'd by registrar) 19..... Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5, 45 at 2:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from For 5 years 19..... to Dec 5 - 19 45 -

and that I last saw h[illegible] alive on Dec 4 - 19 45 -

Immediate cause of death

	DURATION
Heart Failure	2-3 days
Chronic Myocarditis	years
Due to Arterial Hypertension	years
Due to Arterio Sclerosis	years
Other conditions General Physical Emaciation	years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E E Nichols MD M. D. or other

Address P Revere 8 Md. Date signed 12-6-45

RECEIVED
DEC 8 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

12019

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County BALTO.

City or town GRAY MANNOR
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
218 PARKWOOD AVE.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County BALTO.

City or town GRAY MANNOR Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 218 PARKWOOD AVE.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME ANTHONY PAULIKAS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNA PAULIKAS

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) JAN. 19 1879

8. AGE:

Years	Months	Days	If less than one day
66	11	17	____ hrs. ____ min.

9. Birthplace LITHUNIA
(Town, county, and state)

10. Usual occupation LABORER

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace LITH.

MOTHER
14. Maiden name UNKNOWN
15. Birthplace LITH.

16. Informant ANNA PAULIKAS (WIFE)

Address 218 PARKWOOD AVE. GRAY MANNOR

17. BURIAL Date thereof DEC. 19/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18. Funeral director Lilly & Zeiler inc.

Address 403 S. WOLFE ST.

19. Dec 19 19 45 John H. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 17 19 45, at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 19 45, to Dec. 17 19 45;
and that I last saw him alive on Dec 17 19 45.

Immediate cause of death	DURATION
Influenza	1 wk
Due to	
Due to	
Other conditions Bronchopneumonia	3 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations no

Of autopsy no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE James F. White, M.D.
M. D. or other

Address 7601 Eastern ave Date signed 12-19-45
Balto. 24, md

RECEIVED
DEC 27 1945
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

CERTIFICATE OF DEATH

12020

Reg. Diat. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 mths.

Hospital, institution, or street address where death occurred:
605 Carysbrook Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 Carysbrook Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Faye Ann Pearson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 29-1945

8. AGE: Years	Months	Days	If less than one day
	3	13	..... hrs. ..... min.

9. Birthplace: Baltimore Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Laurence E. Pearson

FATHER 13. Birthplace: armstrong allegeis

MOTHER 14. Maiden name: Martha A. Henderson

MOTHER 15. Birthplace: Cincinnatti, Ohio

16. Informant: Laurence E. Pearson

Address: 605 Carysbrook Rd. Subrbk Pk.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville Maryland

18. Funeral director: Frank H. Newell

Address: Pikesville, Maryland

19. 12-13-1945 (Date rec'd by registrar) M. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1945, at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12-11- 1945, to 12-11 1945

and that I last saw her alive on not seen alive 1945

Immediate cause of death	DURATION
Suffocation (Accidental)	20 min.
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12-11-'45

Where did injury occur? Pikesville, (City or town) Balto., (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Suffocation Injured at work? No

23. SIGNATURE: D. D. Caples, M.D.
M. D. or other

Address: Reisterstown, Md. Date signed 12-11-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 17 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1935)

CERTIFICATE OF DEATH

12021 P

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 186 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 186 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1515 McCulloh Street
(If rural, give LOCATION)

2.(a) If veteran, name war: W. W. I

3. (a) FULL NAME
CLARK S. PINN

3. (b) Social Security Number
218-07-6354

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mrs. Bessie Pinn

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): May 20, 1890

8. AGE: Years	Months	Days	If less than one day
55	7	4	...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business

FATHER
12. Name: Frank Pinn
13. Birthplace: Virginia

MOTHER
14. Maiden name: Hanna Hurry
15. Birthplace: Virginia

16. Informant: Clinical Records, Vet. Adm.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 28, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Harlow K. Law

Address: 802 Madison Avenue

19. 12/26 1945 (Date rec'd by registrar) A-W Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945 at 3:00a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1945, to December 25 1945 and that I last saw him alive on December 25 1945

Immediate cause of death	DURATION
UREMIA	2 mos.
Due to: HYDRONEPHROSIS, RIGHT	unknown
Due to:	
Other conditions: CHRONIC CYSTITIS; ABSENCE KIDNEY, LEFT, ACQUIRED; EMPHYSEMA, PULMONARY	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: A. M. BALTER, LT. COL. CLIN. DIREC. (M. D. or other)

Address: Fort Howard, Md. Date signed: ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

12022

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

Eastern Ave. Extended

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. Eastern Ave. Extended

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ETHEL V. PORTER

3.(b) Social Security Number: **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Clinton H. Porter

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1901

8. AGE: Years	Months	Days	If less than one day
44	6	21	hrs. min.

9. Birthplace: Harford Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Henderson Grier Thomas

13. Birthplace: Harford Co., Md.

MOTHER

14. Maiden name: Haddie Cavender

15. Birthplace: Harford Co., Md.

16. Informant: Mr. Clinton H. Porter

Address: Eastern Ave. Extended

17. burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26, 1945 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Chase, Md.

18. Funeral director: Lansdale Funeral Home

Address: 7401 Belair Road

19. Dec 24 1945 (Date rec'd by registrar) John H. Gunell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23rd, 1945 at 9:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1944 to Dec 23 1945 and that I last saw her alive on Dec. 23 1945

Immediate cause of death	DURATION
Carcinoma of Breast	18 mos.
Due to	
Due to	
Other conditions: no	

(Include pregnancy within 3 months of death)

Major findings of operations: see above

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James F. White M.D. M. D. or other

Address: 16 W. Eastern Ave. Baltimore 24, Md. Date signed 12/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 2 1946
BUREAU V M

12023

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Feb 25, 1936

Hospital, Institution, or street address where death occurred:

Rosewood State Training School

How long in hospital or institution? Since Feb 25, 1936

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Florence Barbara Carter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1932

8. AGE: Years	Months	Days	If less than one day
13	10	29	hrs. min.

9. Birthplace Catonsville Baltimore Maryland (Town, county, and state)

10. Usual occupation Pre-vocational Age Juvenile Invalid.

11. Industry or business

FATHER 12. Name Joseph Dell Carter

FATHER 13. Birthplace Catonsville, Maryland

MOTHER 14. Maiden name Florence Ruoff

MOTHER 15. Birthplace Connecticut

16. Informant Rosewood Staff

Address Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 18, 1945 (month) (day) (year)

Cemetery or crematory Meadowridge Memorial Park

Location Washington Boulevard

18. Funeral director E. Ashton Sons

Address Ellicott City, Md.

19 Dec. 15, 1945 (Date rec'd by registrar) M. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1945, at 9:45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13, 1945, to December 15, 1945 and that I last saw h alive on December 15, 1945

Immediate cause of death	DURATION
Bronchopneumonia	5 days
Due to	
Due to	
Other conditions Grand-mal Epilepsy	10 Yrs +
Cerebral Aplasia	10 Yrs +

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Viola Barrett Johns a M MD M. D. or other

Address Rosewood, Owings Mills Md Date signed 12/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 20 1945
BUREAU V.S.

1202 P4

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (07)

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Sollers Point Station
How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Sollers Point Sta
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William F Price

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Caleb H Price
6.(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): Aug 9 1865

8. AGE: Years: 80 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Somerset Co Md (Town, county, and state)

10. Usual occupation:

11. Industry or business: At Home

FATHER
12. Name: William Caren
13. Birthplace: Md

MOTHER
14. Maiden name: Margaret Price
15. Birthplace: Md

16. Informant: Mrs Margaret White
Address: Sollers Point St

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Jan 2 1946 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem
Location: City

18. Funeral director: Ullrich Funeral Home
Address: 2008 Orleans St

19. 1-2-46 (Date rec'd by registrar) 19 CITY HEALTH DEPT. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30th 19 45 at 4 45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25th 19 45, to Dec 30th 19 45
and that I last saw h alive on Dec 30th 19 45

Immediate cause of death	DURATION
Bronchio-pneumonia	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Thomas M.D. M. D. or other
Address: 107 N Main St Dundalk Md Date signed: Jan 1 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 2 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH 12025
2411 N. Charles St., Baltimore (107)
CERTIFICATE OF DEATH
Reg. Dist. No. 41

M

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: 1 month, 1 day
Hospital, institution, or street address where death occurred: Rosewood State Training School
How long in hospital or institution?: 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: 2240 Essex St., Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2240 Essex Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: William Joseph Reda
3.(b) Social Security Number: -

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
8.(b) Name of husband or wife:
8.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): August 4, 1938

8. AGE: Years: 7 Months: 4 Days: 25 If less than one day ... hrs. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Inmate; Rosewood St. Tr. School, Owings Mills, Md.
11. Industry or business:

FATHER
12. Name: Julius William Reda
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Mary Evelyn Wood
15. Birthplace: Baltimore, Md.

16. Informant: Institutional records; Rosewood
Address: State Training School; Owings Mills, Md.

Burial (Burial, cremation, or removal. Which?) Date thereof: January 1, 45 (month) (day) (year)
Cemetery or crematory: Holy Rosary
Location: Baltimore
18. Funeral director: Fred W. Ozazewski
Address: 1930 Eastern Ave.
19. 12/31 1945 (Date rec'd by registrar) [signature] Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29th 19 45, at 7:00 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 21 19 45, to December 29 19 45
and that I last saw him alive on December 29 19 45

	DURATION
Immediate cause of death: Broncho pneumonia	3 days
Due to: Acute bronchitis	7 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: NONE Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Inedairy M.D. M. D. or other
Address: Owings Mills, Md Date signed: 12/29/45

[signature] Reg

I

VS A15 9.45.15M

T

RECEIVED
JAN 8 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12026

Reg. Diat. No. 37

1. PLACE OF DEATH

County: Baltimore

City or town: Corkeysville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address, where death occurred: Masonic Home, Corkeysville Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 -- Wilkins Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Ida L. Riley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John D. Riley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 20 - 1867

8. AGE: Years	Months	Days	If less than one day
78	4	4	hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Henry Lantz

13. Birthplace: Germany

MOTHER — 14. Maiden name: Eliz. Shipley

15. Birthplace: Md.

16. Informant: Laura M. Schroeder

Address: Masonic Home, Corkeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27/45 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Baltimore Md

18. Funeral director: Geo. L. Boyer Jr.

Address: 1512 Hollins St

19. 12/26 (Date rec'd by registrar) 19 45 Laura M. Schroeder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 19 45 at 11 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 19 45 to Dec 24 19 45 and that I last saw h alive on Dec 13 19 45

	DURATION
Immediate cause of death: Cardiac Decompensation	1 day
Due to: Hypertensive Cardio Vascular Disease	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Sid. Sherman M. D.
M. D. or other

Address: 2424 Eutaw pl. Date signed 12/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 27 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

12027

Reg. Diat. No. .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County Baltimore

City or town Raspeburg.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, Institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore.

City or town Roslyn.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 700 Old Home Road.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Katie E. Roeder

3. (b) Social Security Number ✓

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Henry Roeder

If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): April 14, 1890.

8. AGE: Years 55. Months 7 Days 17. If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore. Md. (Town, county, and state)

10. Usual occupation home work

11. Industry or business at home

FATHER 12. Name Henry K. Stair.

13. Birthplace Lorraine

MOTHER 14. Maiden name Madore Hawkins

15. Birthplace Calvert Co., Md.

16. Informant Mr. Henry Roeder.

Address 700 Old Home Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/45 (month) (day) (year)

Cemetery or crematory Western Cem.

Location Edgewood & Edmondson Aves

18. Funeral director John J. Cowan & Son.

Address 901-03 Hollins Street

19. 12/3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1st 1945 at 8.35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1945, to Dec 1945

and that I last saw h.. alive on Nov 30/45 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	7 days
Due to Chr Hypertension	5 years
Due to	
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op. .....

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. S. Harding M. D. or other

Address 4840 Belair Rd Date signed 12/3/45

Balts. Co.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (166)

Registered No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address German Hill Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 12128
(a) State Md (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. German Hill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Fabing Roessler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Tully, N. Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Fabing
13. Birthplace Hewitt N. Y.

MOTHER
14. Maiden Name Jennie Eldridge
15. Birthplace Hewitt N. Y.

16 (a) Informant Josph Fabing
(b) Address Cazenovia N. Y.

17 (a) Burial (b) Date thereof Dec. 10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maplewood Cem.
Location Manlius, N. Y.

18 (a) Funeral director John F. Connelly
(b) Address 418 Eastern Ave. Syracuse

19 (a) Dec 8-45 (b) John F. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July at 1945 ? M.
(b) Where did injury occur? German Hill Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot

23. Signature Robert C. Gruetzner M.D.
Medical Examiner.
Date signed Dec. 8 1945

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

12029 T

Reg. Diat. No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2806 Oakcrest ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Charles Albert Rumpf

3. (b) Social Security Number 218-09-3601

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lillie Mae Rumpf
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 9th 1891

8. AGE: Years	Months	Days	If less than one day
54	1	24	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Sheet Metal Worker
11. Industry or business Metal Works

FATHER
12. Name Charles A. Rumpf
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden name Louise Heiger
15. Birthplace Baltimore, Maryland

16. Informant Mrs Chas A. Rumpf
Address 2806 Oakcrest ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6th 1945 (month) (day) (year)
Cemetery or crematory Western Cemetery
Location Baltimore, Maryland

18. Funeral director Lassahn Funeral Home
Address 7401 Belair Road

19. 12/5 1945 (Date rec'd by registrar) G. W. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1945 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death None	
Heart disease, vascular coronary	12/3/45
Due to Hypertension	5 mo +
Due to Arteriosclerosis	Unk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Rollin E. Hudson MD DME
M. D. or other
Address Towson Md Date signed 12/3/45

RECEIVED
DEC 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12030 P

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 8 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 6 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3102 Oakfield Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Nathan A. Sachs

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Rebecca Bluebond

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): [illegible] 1882

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: cake salesman

11. Industry or business: baking

FATHER — 12. Name: Louis Sachs

FATHER — 13. Birthplace: Russia

MOTHER — 14. Maiden name: Yetta Cohen

MOTHER — 15. Birthplace: Russia

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 12, 1945 (month) (day) (year)

Cemetery or crematory: Hebrew Herring Run Cemetery

Location: Bowleys Lane

18. Funeral director: Sol Levinson & Bros

Address: 1124-1126 W North Ave

19. 12/15 (Date rec'd by registrar) 19 45 A.W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11, 1945, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3, 1945, to Dec. 11, 1945 and that I last saw him alive on Dec. 11, 1945

Immediate cause of death	DURATION
Pulmonary edema	5 days
Due to: Myocardial insufficiency	1 week
Due to: Hypertensive cardiovascular disease	Indef.
Other conditions: Arteriosclerosis	Indef.

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the canse to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

Isadore Tuerk

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed 12/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

12031 P

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Balto.
City or town: Glyndon Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place at death? 1½ years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Albright Ave. & Central Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry H. Shaw

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mamie K. Shaw
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 14, 1892

8. AGE: Years	Months	Days	If less than one day
53	6	24	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Retired - Ship Fitter
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Mamie K. Shaw
Address: Central & Albright Aves. Glyndon

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/12/45 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore, Md.

18. Funeral director: Wm. J. Tickner & Sons, Inc.
Address: North & Pa. Aves. Baltimore, Md.

19. 12/13 19 45 A W Kedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1945 at 1:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 1945, to Dec 8 1945 and that I last saw him alive dead on 12-8 1945

Immediate cause of death	DURATION
Hanging	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date at 12-8-'45
Where did injury occur? Glyndon (City or town) Balto. (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Hanging Injured at work? No.

23. SIGNATURE: Dr. D. D. Earles Medical Examiner M. D. or other
Address: Reisterstown, Md Date signed: 12-8-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12032

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176)

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred Bethlehem Steel
How long in hospital or institution? (at work)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town ~~Sparrows Point~~
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dundalk 103 Palazzo ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elijah Shiflett
3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Josephine Shiflett
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): About ~~1900~~ 1903

8. AGE: Years: Abt 42 | Months: – | Days: – | If less than one day ... hrs. ... min.

9. Birthplace: Booneville-Va.
(Town, county, and state)
10. Usual occupation: Steel Worker
11. Industry or business: Bethlehem Steel Co

FATHER
12. Name: Edw. Shiflett
13. Birthplace: Virginia

MOTHER
14. Maiden name: unknown
15. Birthplace: Virginia

16. Informant: Mrs Lula Morris (friend)
Address: Dundalk-Md

17. burial — Date thereof 1-3-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Pine Hill
Location: Booneville-Va.
18. Funeral director: Stewart Mann Co.
Address: 108 W. North Ave.

19. 1/1/46 — [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1945, at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Injured by Ingot Buggy —	
1. Multiple Fractures to Left Rib's & Crushing Injury to Chest.	
2. Compound fracture & partial Amputation Rt. foot.	35 min
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident — Date of 12-31-45
Where did injury occur? Beth. Steel - Sp. Point Balt Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Industry
Means of injury: Struck by Ingot Buggy — Injured at work? No

23. SIGNATURE [illegible] Davis M.D. or other
Dep. Med. Exam. - Balto Co.
Address: Dundalk [illegible] Md — Date signed 1/1/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 8 1946
BUREAU V.S.

12033

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson Rt 1 Dist Cub Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Patricia Ann Skinner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3, 1945

8. AGE: Years | Months: 5 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Baltimore Co. Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Howard B. Skinner

13. Birthplace: Baltimore, Md

MOTHER 14. Maiden name: Louise C. Brown

15. Birthplace: Baltimore Md

16. Informant: Howard B. Skinner

Address: Cub Hill Balto Co. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12-4-45 (month) (day) (year)

Cemetery or crematory: Mt. Carmel Cem.

Location: Balto.

18. Funeral director: Leonard M. Rank

Address: 5305 Harford Rd.

19. 12/3 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 19 45, at 7:17 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 to 19

and that I last saw h alive on 19

Immediate cause of death'	DURATION
Pneumonia, Lobar Left	Dec 1, 1945
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bollie C. Hudson M.D. D.M.E.

M. D. or other

Address: Towson Md. Date signed 12/2/45

Dr. Grott

12034

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Fullerton
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
West Joppa Road,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Fullerton
City or town: Baltimore Road
(If outside city or town limits, write RURAL and give nearest town)
Street No.: West Joppa Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Joanna M. Padgett Slaughter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Adolphus Slaughter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1859

8. AGE: Years	Months	Days	If less than one day
86	1	24	..... hrs. ..... min.

9. Birthplace: Anne Arundel Co.
(Town, county, and state)
10. Usual occupation: At home
11. Industry or business

FATHER
12. Name: ? Cadle
13. Birthplace: Maryland

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mrs. William H. Beck
Address: West Joppa Road, Fullerton

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Baltimore

18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road -14-

19. 12/3/45 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1st, 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1, 1945, to Nov. 30 1945 and that I last saw h.er alive on Nov. 30 1945

Immediate cause of death	DURATION
Pulmonary edema	3 d.
Due to Hypertension	
Cardiovascular	3 yr.
Due to Cirrhosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. A. Grott, M. D.
M. D. or other
Address: 8100 Harford Rd Date signed 12/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (92-D)

Registered No. 12035 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Town
(c) Hospital or institution: Presbyterian Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) since 1929

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emiley L Snow

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/55

8. AGE: Years	Months	Days	If less than one day
90	9	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retires
11. Industry or business

FATHER
12. Name Wm. Freeman Snow
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Cynd Conradt
15. Birthplace Fredrick Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director John O. Fifield & Sons
(b) Address 1900 Eutaw Place

19 (a) 12/17/45 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/45 19 , at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 45 19 45, to Dec 14 19 45, and that I last saw h[illegible] alive on Dec 14 19 45.

Immediate cause of death	Duration
Myocardial degeneration	1 yr.
Due to Arter. Sclerosis	mo
Due to + Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Towson Md Date signed 12/17/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline **that particular ONE** cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which **might** have contributed to the **risk of dying,** but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-C

CERTIFICATE OF DEATH

12036 32
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Garrison (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. Rolling Road (If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Mary Jane Snyder

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Frank Snyder
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) NOV 26 - 1881

8. AGE: Years	Months	Days	If less than one day
64	1	2	..... hrs. ..... min.

9. Birthplace Ireland (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Mr. Wm Knapp
FATHER 12. Name Peter Brady
FATHER 13. Birthplace Ireland
MOTHER 14. Maiden name Jane Brady
MOTHER 15. Birthplace Ireland
16. Informant James Snyder - (Son)
Address Owings Mills P.O. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/45 (month) (day) (year)
Cemetery or crematory St. Charles
Location Pikesville, Md.
18. Funeral director Frank H. Newell
Address Pikesville, Maryland
19. 12/31/45 (Date rec'd by registrar) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945, at 3 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1945 to Dec 28 1945 and that I last saw h.e.r. alive on Dec 28 1945

	DURATION
Immediate cause of death Grippe	2 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. D. Eagles, M.D. M. D. or other
Address Reisterstown, Md. Date signed 12-29-45

RECEIVED
JAN 7 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 94a

Reg. Dist. No. 44

CERTIFICATE OF DEATH

12037

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Stemmers Run
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
Stemmers Run Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Stemmers Run
(If outside city or town limits, write RURAL and give town)
(d) Street No. Stemmers Run Road
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Ella May Sponheimer

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John W. Sponheimer

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 13, 1908

8. AGE: Years	Months	Days	If less than one day
37	5	9	____hr. ____min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Frank Sigrist
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Lula Suehs
15. Birthplace Balto., Md.

16 (a) Informant Mr. J. W. Sponheimer
(b) Address Stemmers Run Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run, Md.

18 (a) Funeral director Loudenslager Funeral Home
(b) Address 7401 Belair Road

19 (a) 12/26/45 (Date rec'd by registrar) (b) Dawson L. Barber Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 22 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1945, to Dec 22 1945, and that I last saw him alive on Dec 22 1945.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions Ca Uterus	3 days.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. W. Baumgardner
M. D. or other
Address Balto 6 Md Date signed 12-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 27 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39a)

12039

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

304 Bayside Drive.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Dundalk.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Bayside Drive.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Theresa Steever (Wolf)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife George M. Steever

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1879

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual occupation at Home

11. Industry or business

FATHER 12. Name Joseph D. Zillmore

13. Birthplace Germany.

MOTHER 14. Maiden name Unknown

15. Birthplace Germany.

16. Informant George Steever

Address 304 Bayside Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/46 (month) (day) (year)

Cemetery or crematory Sacred Heart.

Location German Hill Rd.

18. Funeral director John J. Connelly.

Address 418 Eastern Ave. Essex 21

19. 1/2/ 1946 (Date rec'd by registrar) John J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29, 1945 at 6 40 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20, 1945 to Dec 29, 1945 and that I last saw h.. alive on Dec 28 1945

Immediate cause of death	DURATION
Myocarditis (acute)	10 d.
Due to Hypertension	8 yrs
Due to arteriosclerosis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard N. Andrews M.D. M. D. or other

Address 2 Kenilworth Rd Elkridge Md Date signed 1/2/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12038

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 408 Markland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-1

3.(a) FULL NAME: WALTER CARROLL STEVENS

3.(b) Social Security Number: 217-20-7414

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Rosalie A. Stevens
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): November 1, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	14	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Marine Pipefitter
11. Industry or business

FATHER
12. Name: William E. Stevens
13. Birthplace: Harford Co, MARYLAND

MOTHER
14. Maiden name: Isabella Beadenkopf
15. Birthplace: Harford Co, Maryland

16. Informant: Vets. Adm. Clinical Records,
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/18/1945 (month) (day) (year)
Cemetery or crematory: Govans Presbyterian
Location: Baltimore, Maryland

18. Funeral director: Sasaki Funeral Home
Address: 7401 Belair Road

19. Dec. 25 1945 (Date rec'd by registrar) D-L. Farber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15, 1945, at 12:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6 1945, to December 15 1945 and that I last saw h.im alive on December 15, 1945

Immediate cause of death	DURATION
Carcinoma of Bladder	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L L Ochs M. D. or other
Address: Ft Howard. Date signed: 12-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
DEC 27 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12040

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Md.
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 113 S. Stockton St.
(If rural, give LOCATION)
2.(a) If veteran, name war: SAW

3.(a) FULL NAME: ALBERT STEWART

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	married

6.(b) Name of husband or wife: Agnes Stewart
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE:	Years	Months	Days	If less than one day
	69			....hrs. ....min.

9. Birthplace: A. A. Co., Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: xxxxxx Perry Stewart
13. Birthplace: A. A. Co., Md.

MOTHER
14. Maiden name: xxxxxx Sarah Neal
15. Birthplace: A. A. Co., Md.

16. Informant: Vets. Adm. Clinical Records
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 24, 1945 (month) (day) (year)
Cemetery or crematory: National Cem
Location:

18. Funeral director: Mrs Katie R. Williams
Address: 322 N Schroeder St

19. 12/24/ 19 45 (Date rec'd by registrar) Huntington Williams Registrar
City Health Dept.

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 19 45 at 10:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6, 19 45 to December 18 19 45 and that I last saw him alive on December 18 19 45

Immediate cause of death	DURATION
Pneumonia, lobular	3 days
Due to	
Due to	
Other conditions: Malnutrition, severe	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. Y. RICHARDS, MAJOR, M.C. ACT. CLIN. DIR.
Veterans Administration M. D. or other
Address: Fort Howard, Md. Date signed: 12-19-45

VS A15 9.45-1

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12/32

Reg. Dist. No. 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Rockdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 3518 St. James Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Rockdale (If outside city or town limits, write RURAL and give nearest town)

Street No.: 3518 St. James Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Herman Stierhoff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Florence Emma Stierhoff

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 19, 1859

8. AGE:	Years	Months	Days	If less than one day
	86	7	5	..... hrs. ..... min.

9. Birthplace: Pikesville, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: John Stierhoff

FATHER — 13. Birthplace: Baltimore County, Md.

MOTHER — 14. Maiden name: Katharine Bayer

MOTHER — 15. Birthplace: Baltimore County, Md.

16. Informant: Mrs. William H. Damm

Address: 3518 St. James Road, Rockdale

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 27, 1945 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Pikesville, Md.

18. Funeral director: Willis Lemmon

Address: 4510 Liberty Heights Ave.

19. Dec 26 1945 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 1945, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11 1945 to Dec 24 1945

and that I last saw him alive on Dec 23 1945

Immediate cause of death	DURATION
Severe Concussion of right hip - probable fracture	6 wks
Due to: Fell down cellar steps	6 wks
Due to:	
Other conditions: Shock & Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of Nov 11 1945

Where did injury occur? At his home (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury: Fell down steps Injured at work? no

23. SIGNATURE: E E Nichols M.D. (M. D. or other)

Address: 1402 Reisterstown Rd Pikesville, Md. Date signed: 12-26-45

RECEIVED
DEC 27 1945
BUREAU V.S.

12042

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? --------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 Fusting Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: --------

3.(a) FULL NAME: Mary Addison Page Stiles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Lee Stiles
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): May 26, 1859

8. AGE: Years	Months	Days	If less than one day
86	7	4	-- hrs. --- min.

9. Birthplace: Frederick, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: --------

FATHER
12. Name: Walker Yates Page
13. Birthplace: Virginia

MOTHER
14. Maiden name: Christianna Tyler
15. Birthplace: Virginia

16. Informant: Mrs. William T. Haydon
Address: 137 W. Lafayette Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/46 (month) (day) (year)
Cemetery or crematory: Lorraine
Location: Woodlawn, Md.
18. Funeral director: H. C. Mears and Son
Address: 805 N. Calvert Street

19. 12/31/45 (Date rec'd by registrar) Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1945 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14 1943 to Dec. 30 1945 and that I last saw h-- alive on Dec. 29 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	3 da.
Due to: Fractured Right Hip	6 da.
Due to: Accidental fall. An aged person who fell out of bed.	
Other conditions: Senile Dementia	3 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: December 24th, 1945
Where did injury occur? Catonsville-28, (City or town) Baltimore, (County) Maryland (State)
Injured at home, farm, industry, public place (where?): 16 Fusting Avenue
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Wilmer K. Gallagher M.D. (M. D. or other)
Address: Catonsville-28, Md. Date signed: 12-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 2 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

12043

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore County

City or town: Glyndon (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

~~Hospital, institution,~~ or street address where death occurred: 15 Chatsworth Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Glyndon (If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Chatsworth Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Katherine A.K. Stocksdale

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Howard H. Stocksdale 6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 30, 1877

8. AGE: Years: 68 Months: 7 Days: 29 If less than one day: ...hrs. ...min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER 12. Name: August Carl

FATHER 13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Katherine Kline

MOTHER 15. Birthplace: Baltimore, Md.

16. Informant: Howard Stocksdale

Address: Glyndon,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2, 1946 (month) (day) (year)

Cemetery or ~~crematory~~: Lutheran

Location: Reisterstown,

18. Funeral director: Wm. Beverungen & Sons

Address: Reisterstown, Md.

19. Dec 31 1945 (Date rec'd by registrar) Dana S. Fine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1945 at 11 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary thrombosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ...

Means of injury: ... Injured at work?

23. SIGNATURE: J. Walter Landau, M.D. M. D. or other

Address: Reisterstown Md. Date signed: 12-31-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 3 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

12144

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson,

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Presbyterian Home

Stay in hospital or inst. (yrs., or mos., or days): 5 yrs.

Stay in this community (yrs., or mos., or days): 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Towson, Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Presbyterian Home

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Elizabeth H. Sturgeon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 2, 1868

8. AGE:

Years	Months	Days	If less than one day
77	2	9	hrs. min.

9. Birthplace: Pitts. Pa. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business:

FATHER — 12. Name: Archibald C. Sturgeon

13. Birthplace: Pitts. Pa.

MOTHER — 14. Maiden name: Mary McClain

15. Birthplace: Pitts. Pa.

16. Informant: Records Presbyterian Home

Address: Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/13/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemy.

Location: Fred. Ave. Balto. Md.

18. Funeral director: Johns O. Mitchell Home Inc.

Address: 1900 Eutaw Place

19. Dec. 12 1945 (Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11, 1945, at 9A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 10 1945, and that I last saw her alive on Dec 10 1945

Immediate cause of death	DURATION
Apoplexy	10 days.
Due to Arterio-Sclerosis & Hypertension	years
Due to	months
Other conditions	days

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Glenn Dorsey M.D. or other

Address: Towson-4-Md. Date signed 12/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 29 1945
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

RC 12045 B

Reg. Diat. No. 30

1. PLACE OF DEATH

County: Balto Co.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 MON.

Hospital, Institution, or street address where death occurred: House in Pines

76 Fusting Ave.

How long in hospital or institution? 1 MON

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto City

City or town: Cato

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chelsea Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Eleanor H. Sutherland

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W.

6.(b) Name of husband or wife: Frederick

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 17-1865

8. AGE: Years	Months	Days	If less than one day
80	3	14	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: John Holland

FATHER — 13. Birthplace: Balto

MOTHER — 14. Maiden name: Eleanor ?

MOTHER — 15. Birthplace: Balto.

16. Informant: Mrs. Flora Trentholm

Address: 212 Ridgewood Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/46 (month) (day) (year)

Cemetery or crematory: London Pk.

Location: Balto.

18. Funeral director: Wm Cook Inc

Address: 217 St Paul St

19. 1/2/46 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31. 19 45. at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 40, to Dec 31 19 45.

and that I last saw h. alive on Dec 30 19 45

Immediate cause of death	DURATION
Cerebral Thrombosis	2 days
Due to: Arteriosclerosis	4 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M Bunnan Hood M. D. or other

Address: 2200 Guilford Blvd Date signed 1-2-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12046 P

STATE OF MARYLAND
CERTIFICATE OF DEATH

(92d)

Registration Dist. No. .....

1 PLACE OF DEATH

County Baltimore

Village or City Dundalk P.O. (No. ..... Roseland Ave St.: ..... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Szlachetka SZLACHETKA

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH ? (Month) (Day), 1880 (Year)

7 AGE 65 yrs. ..... mos. ..... ds. | If LESS than 1 day ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Poland

PARENTS

10 NAME OF FATHER George Szlachetka

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Zimk.

13 BIRTHPLACE OF MOTHER (State or country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Teofila Szlachetka

(Address) Box 327 Dundalk Road

15 Filed 12/29 1945 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 25, 1945
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1945 to Dec 25, 1945 that I last saw him alive on Dec 25, 1945 and that death occured on the date stated above, at 4 P. m.

The CAUSE OF DEATH * was as follows:

Pulmonary Stenosis

(Duration) ? yrs. ..... mos. ..... ds.

Contributory Secondary Chronic Passive Congestion of Brain + Lungs (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) M. C. Jacobs M. D.

Dec 26 1945 (Address) 617 North Mc Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Sacred Heart | DATE OF BURIAL Dec. 31, 1945

20 UNDERTAKER Fred W. Ozazewski | ADDRESS 1930 Eastern Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1

N B.—Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Solesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return 'Laborer,' "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

12047

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Perry Hall
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:
Belair Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Perry Hall
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Belair Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: JOHN TANNER

3. (b) Social Security Number: **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lena Tanner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 12, 1860

8. AGE:	Years	Months	Days	If less than one day
	85	2	19	..... hrs. ..... min.

9. Birthplace: Austria
(Town, county, and state)

10. Usual occupation: Brick Layer

11. Industry or business

FATHER — 12. Name: John Tanner

FATHER — 13. Birthplace: Austria

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Mr. John Tanner, Jr.

Address: Belair Road, Fullerton, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3, 1945 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore, Md.

18. Funeral director: Lonabaw Funeral Home

Address: 7401 Belair Road

19. 12/2/45 (Date rec'd by registrar) J. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1st, 1945 at 12:50 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 26 19.. to Dec 1 19 45

and that I last saw h.. alive on Nov 30 19 45

Immediate cause of death: Cerebral Hemmorhage — DURATION: 5 days

Due to:

Due to:

Other conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Walter A. Anderson M. D. or other

Address: 300 Shannon Drive Date signed: 12-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 20 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12048

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Texas, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Texas

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Texas Lane

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph LeRoy Thompson

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1944

8. AGE: Years	Months	Days	If less than one day
1	2	10	hrs. min.

9. Birthplace: Texas Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER — 12. Name: Charles R Thompson Jr

FATHER — 13. Birthplace: Texas, Maryland

MOTHER — 14. Maiden name: Mary E Mobley

MOTHER — 15. Birthplace: Balto., Md.

18. Informant: Chas. R. Thompson, Jr.

Address: Texas, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 1, 1946 (month) (day) (year)

Cemetery or crematory: St. Josephs

Location: Texas, Maryland.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Dec. 31 (Date rec'd by registrar) 45 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 1945, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death: Pneumonia, Lobar	1 day
Due to: Left	
Due to:	
Due to:	
Other conditions: Heart disease, chronic, congenital, valvular	14 mo

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Rollin L. Hudson MD DMD (M. D. or other)

Address: Towson 4 Md Date signed 12/30/45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 2 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12049

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Sutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Sutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Clark & Ballona
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Benjamin Evans Turnbaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1943

8. AGE:

Years	Months	Days	If less than one day
2	0	24	hrs. min.

8. Birthplace Balto. Co. Texas Md. (Town, county, and state)

10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name Helen Amelia Turnbaugh
15. Birthplace Sutherville Balto Co. Md.

16. Informant Walter Turnbaugh Sr.
Address Sutherville, Md.

17. Burial (Burial, cremation, or removnl. Which?) Date thereof 12 10. 45 (month) (day) (year)
Cemetery or crematory Trinity Episcopal
Location Glen Arm, Md.

18. Funeral director L. Scott Brooks.
Address Sparks, Md.

19. Dec 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1945, at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/8 1945, to 12/7 1945 and that I last saw h... alive on 12/7 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	24 hrs
Due to Congenital heart disease E	
polycythemia	life
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clewell Howell M.D
M. D. or other
Address Towson, Md Date signed 12/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 29 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

12050 P

2411 N. Charles St., Baltimore (3d)

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Opit, Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new born infants give residence of mother)

State Md. County Balto.

City or town Glenarm
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural Free Manor Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FANNIE M. WADE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Benj. H. Wade

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 20, 1863

8. AGE: Years	Months	Days	If less than one day
82	4	11	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joshua Proctor

13. Birthplace: Md.

MOTHER — 14. Maiden name: Maria ?

15. Birthplace: Md.

18. Informant: Mr. Proctor S. Wade

Address: 4609 Linden Ave., Halethorpe

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/46 (mooth) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 1/2 19 46 A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 40, to Dec 29 19 45

and that I last saw her alive on Dec 29 19 45

	DURATION
Immediate cause of death: Stroke	1 Week
Due to: Arteriosclerotic Heart disease with	
Due to: Decompensation	5 yrs
Other conditions: Phlebitis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Walter M. Hammett M. D. or other

Address Baldwin Date signed 1/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

12051 30

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Mt. Home

How long in hospital or institution? 3

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No.: Edmondson Ave. Frederick Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Richard Stable

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife: Wilhelmina Stable

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 24 1848

8. AGE: Years	Months	Days	If less than one day
97	11	23	— hrs. — min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Henry Stable

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Augusta Behrens

MOTHER — 15. Birthplace: Germany

16. Informant: Stable

Address: 2573 Woodbourne Ave

17. Interment (Burial, cremation, or removal—Which?) Date thereof 12/20/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore Md

18. Funeral director: F. P. Wippert Inc.

Address: 1300 Eutaw Place

19. 12/20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17th 1945 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1944, to Dec 17 1945

and that I last saw him alive on Dec 15 1945.

Immediate cause of death	DUR
Pneumonia Terminal	
Staphylococcus	3 days
Due to: Cerebral Sclerosis	
General Senile	5 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elliot W. Johnson M. D. or other

Address: 3432 Druid Park Ave Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12053

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Spring Grove

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1654 Round Hill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: PAULINE WALTERS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Henry Walters

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 11, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	13	hrs. min.

8. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: -- Heintz

13. Birthplace: Germany

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs. William Hayer

Address: 1564 Round Hill Rd. Balto. 18, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/27/45 (month) (day) (year)

Cemetery or crematory: Western Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 12/26 (Date rec'd by registrar) 19 45 A W Hedgman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 19 45 - 6-30P at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

acute cardiac failure

Due to .....

Due to Coronary Sclerosis

Other conditions Diabetes diuretic

fainting

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. M. Kieffer Clerk Med Exam Balto. M. D. or other

Address: 1010 Leadenhall Date signed: 12-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

12052

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 3d

1. PLACE OF DEATH:

County Balto Co.

City or town Catonsville Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days.

Hospital, institution, or street address where death occurred: 55 of Edmondson ave

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto Co

City or town Catonsville Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 3 S Prospect ave (If rural, give LOCATION)

2.(a) If veteran, name war World war 1

3. (a) FULL NAME John G. Watt

3. (b) Social Security Number

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced Married.

6.(b) Name of husband or wife Gertrude

6.(c) If alive, give age ...... years

7. Birth date of deceased (mo., day, yr.) Oct 16 1899

8. AGE: Years 46 Months Days If less than one day ...... hrs. ...... min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Manager.

11. Industry or business Freight

FATHER 12. Name James Watt

13. Birthplace Scotland

MOTHER 14. Maiden name Jessie Shearer.

15. Birthplace Scotland

16. Informant Gertrude Watt

Address #3 S Prospect ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/6/45 (month) (day) (year)

Cemetery or crematory St Michaels

Location Frostburg Md.

18. Funeral director Eddie C MacNabb

Address Catonsville Md

19. 12-4 1945 Harry H. Muller (Deputy) Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1945, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1943 to Dec 2 1945

and that I last saw him alive on Nov. 28 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 wk.
Due to Carcinoma of Lung	6 mo.
Due to Bronchiectasis	2 yrs?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...... Date of op. ......

Autopsy results ......

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ...... Date of ......

Where did injury occur? ...... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ...... Injured at work?

23. SIGNATURE George Ellison M.D. — M. D. or other

Address Catonsville, 28 Md Date signed 12-2-45

RECEIVED
DEC 5 1945
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12054 C

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4413 Old York Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ada Florence Wiener

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Andrew J. Wiener
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): May 6 1877

8. AGE:	Years	Months	Days	If less than one day
	68	6	25	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None
FATHER 12. Name: Jacob Kephlinger
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: "
16. Informant: Hospital Records
Address: Catonsville 28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-4-45 (month) (day) (year)
Cemetery or crematory: Woods Presby. Cem.
Location: Balto.
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Rd-14-
19. 12/3/45 (Date rec'd by registrar) 19 ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1st 1945 at 11:25A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 29 1945, to Dec. 1st 1945
and that I last saw her alive on December 1st 1945

	DURATION
Immediate cause of death: Terminal left lower lobar pneumonia	20 hrs
Due to: Chronic hypertensive arteriosclerotic C-V disease	Indef.
Due to:	
Other conditions: Chronic generalized osteo-arthritis	"

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None held
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead, M. D. M.D. or other
Address: Catonsville, 28, Md. Date signed: 12/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

12055

CERTIFICATE OF DEATH

Reg. Diat. No. 34

1. PLACE OF DEATH:
County Baltimore
City or town Upperco (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Upperco (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Irvin Gilbert Wilhelm

3.(b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of ~~husband~~ or wife Amanda E Rhoten

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Oct 13-1907

8. AGE:

Years	Months	Days	If less than one day
38	2	8	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation General Laborer

11. Industry or business

FATHER 12. Name Irvin T Wilhelm

13. Birthplace Maryland

MOTHER 14. Maiden name Grace E Harris

15. Birthplace Maryland

16. Informant Mrs I Gilbert Wilhelm

Address Upperco Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-23-45 (month) (day) (year)

Cemetery or crematory Houston

Location Balto. Co. Md

18. Funeral director Edw S Tipton

Address Hampstead Md

19. Dec. 22 (Date rec'd by registrar) 1945 C E Forth M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, at 1:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1936, to Dec. 21 1945 and that I last saw him alive on Dec. 20 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mamie C. Porter M.D. or other

Address Hampstead, Md Date signed 12-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 26 1945
BUREAU OF M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12056

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:
Vets.Adm.Hosp. Fort Howard, Maryland

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 124 N. Wolfe St.
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW ✓

3.(a) FULL NAME

CHARLES WILSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1877

8. AGE:	Years	Months	Days	If less than one day
	68	5	5	hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: Philadelphia, Pa.

MOTHER
14. Maiden name: ? Klettenger
15. Birthplace: Philadelphia, Pa.

16. Informant: Clinical Records, Vets.Adm.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-21-45 (month) (day) (year)

Cemetery or crematory: Balt. National

Location: Frederick Road

18. Funeral director: Oden Funeral Home

Address: 4644 York Road

19. 12/19/45 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 1945, at 1:55 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 10, 1945 to December 17 1945 and that I last saw him alive on December 17 1945

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	3 yr.
Due to	
Due to	
Other conditions: Cerebral Arteriosclerosis; Suppurative Arthritis, rt. elbow; Chr. Hypertrophic Arthritis, lumbar spine	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H.Y. RICHARDS, MAJOR, M.C. ACT. CLIN. M. D. or other DIR.

Address: Vets.Adm. Ft.Howard, Md. Date signed: 12-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

12067

Reg. Dist. No. 7-8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Overlea

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

6813 Belair Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Overlea

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6813 Belair Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: FRED E. WILSON

3. (b) Social Security Number: **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elsie I. Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 20th, 1886

8. AGE: Years	Months	Days	If less than one day
59	11	0	..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: Dentist

11. Industry or business

FATHER 12. Name: Eugene Wilson

13. Birthplace: New York

MOTHER 14. Maiden name: Mary Schauffler

15. Birthplace: New York

16. Informant: Mrs. F. E. Wilson

Address: 6813 Belair Road, Balto. 6, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1945 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore, Md.

18. Funeral director: Lawsha Funeral Home

Address: 7401 Belair Road

19. Dec. 22 19 45 Mo. G. L. Reifsnider

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20th, 19 45 at 4:15P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 19 44 to Dec 20 19 45 and that I last saw h. alive on Dec 20 19 45

Immediate cause of death	DURATION
Coronary heart disease	1 yr 3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A Lee Harland M.D. M. D. or other

Address: 4116 Northern Parkway Date signed: 12/24/45

RECEIVED
DEC 26 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

12058

Reg. Dist. No. 35

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural — Freeland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Minnesota County: [redacted]

City or town: Duluth

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5802 Raleigh St

(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: George ZAKULA

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1923

8. AGE: Years	Months	Days	If less than one day
22	2	9	..... hrs. ..... min.

9. Birthplace: Duluth, Minnesota. (Town, county, and state)

10. Usual occupation: Merchant Seaman

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace

MOTHER — 14. Maiden name: Unknown

15. Birthplace

16. Informant: Fleetwood J. Morin

Address: Duluth, Minnesota

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23, 1945 (month) (day) (year)

Cemetery or crematory: Duluth

Location: Duluth, Minnesota

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Dec. 29, 1945 (Date rec'd by registrar) Mrs. Howard S. Markline, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18 1945, to Dec. 18 1945

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Head Injury - Fractured Skull	
Exposure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12/18/45

Where did injury occur? Freeland (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Park Right of Way

Means of injury ..... Injured at work? .....

23. SIGNATURE: A. M. France M. D. or other

Address: Parkton, Md. Date signed 12/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 2 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Balto

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 82

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Amanda Robinson Zenk

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widow.

6.(b) Name of husband or wife: John C. Zenk

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1864

8. AGE:

Years	Months	Days	If less than one day
81	2	29	hrs. min.

9. Birthplace: Butler, Balto. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: David Robinson

13. Birthplace: Virginia

MOTHER

14. Maiden name: Sadah P. Merryman

15. Birthplace: Balto. Co.

16. Informant: Mrs. Carrie Hollis

Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 4 45 (month) (day) (year)

Cemetery or crematory: Jessops Methodist

Location: Sparks, Md.

18. Funeral director: J. Scott Brooks

Address: Sparks Md

19. Dec 7 (Date rec'd by registrar) 1945 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 1945 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1945, to Dec 1 1945

and that I last saw h.. alive on Dec 1 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Arteriosclerosis	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D. M. D. or other

Address: Cockeysville Md. Date signed 12/7/45

RECEIVED
DEC 5 1945
BUREAU V.S.